World Vision Relief and Development, Inc.

Dhaka Urban Integrated Child Survival Project (DUICSP)

Final Evaluation

September 18-30, 1997
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List of Acronyms

ADB		Asian Development Bank
ADP		Area Development Program
ALRI/ARI		Acute Lower Respiratory Infection
AVSC		Access to Voluntary and Safe Contraception
BASICS		Basic Support for Institutionalizing Child Survival
BCG		Bacillus Calmette-Guerin
BHR		Bureau for Humanitarian Response
CBDS		Community-based disease surveillance
c c c	-	Central Coordination Committee
CCULB	-	Cooperative Credit Union League of Bangladesh
CDD	-	Control of Diarrheal Disease
CDW	-	Community Development Worker
CQI	-	Continuous quality improvement
c s	-	Child Survival
c v	-	Community Volunteer
DCC		Dhaka City Corporation
DIP		Detailed Implementation Plan
DPT	-	Diphtheria, pertussis, tetanus
DUICSP	-	Dhaka Urban Integrated Child Survival Project
ESP		Essential Services Package
EPI		Expanded Program on Immunization
FMG	-	Focus Mother's Group
FP	-	Family planning
FY	-	Fiscal year
GOB		Government of Bangladesh
GO		Government organization
HEMA		Handicraft Education and Marketing Association
HIV		Human Immuno-Deficiency Virus
HMIS		Health management information system
ICDDR,B		International Center for Diarrheal Disease and Research, Bangladesh
IEC	-	Information, education, and communication
IPHN		Institute of Public Health Nutrition
KPC	-	Knowledge, practice, coverage
MCH		Maternal and Child Health
MOHFW		Ministry of Health and Family Welfare
NCESR	-	National Coverage Evaluation Survey Results
NGO		Non-governmental organization
NHC		Neighborhood health committee
NID		National Immunization Days
NRU		Nutrition Rehabilitation Unit
OPV		Oral polio vaccine
ORS		Oral rehydration solution/salts
ORT		Oral rehydration therapy
PHN		Public Health Nurse

PLA	Participatory Learning and Action
PSTC	Population Services and Training Centre
PVC	Private Voluntary Cooperation
PVO	Private Voluntary Organization
QIP	Quality Improvement Project
SACV	Survival Association of Community Volunteers
SCF/UK	Save the Children Federation, United Kingdom
STD	Sexually-transmitted disease
TBA	Traditional birth attendant
TT	Tetanus toxoid
u o o	Urban Operations Officer (BASICS)
UNICEF	United Nations International Children's Emergency Fund
USAID	United States Agency for International Development
USDP	Urban Service Delivery Partnership
UTPS	Unity Through Population Services
VAC	Vitamin A capsule
WHO	World Health Organization
WVB	World Vision Bangladesh
w v c s	World Vision Child Survival
WVRD	World Vision Relief and Development (headquarters)

Acknowledgements

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The Team would also like to congratulate both the DUICSP staff and volunteers for a job well done.

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1. Summary and Recommendations

a. Evaluation Methods, Sites Visited, Dates of Field Work

The evaluation was conducted from September 18 to 30, 1997. The following methods were used:

- A final 30cluster survey, compared to baseline data;
- A review of data collected in the Health Management Information System (HMIS);
- Interviews with USAID, headquarters and local staff from non-governmental organizations (NGOs) in the project area, senior World Vision Bangladesh (WVB) management, the DUICSP staff, and volunteers at all levels [e.g. Central Coordination Committees (CCCs), Neighborhood Health Committees (NHCs), Community Volunteers (CVs), Focus Mother's Groups (FMGs), and Traditional Birth Attendants (TBAs)] in four clusters selected at random;
- Participatory Learning and Action (PLA) exercises developed, conducted, and reported by the community;
- Visits to the Mohammedpur Clinic and one of two clinics in Kamalapur. (A visit to the Kamalapur sub-center clinic could not be made due to two hartels and two afternoon floods.);
- A costing study;
- A review of project reports and records, concentrating on the third phase (final three years) of the project; and,
- Data review meetings and a half-day workshop to discuss findings and recommendations.

The evaluation was conducted according to both BHR/PVC Guidelines for Final Evaluation of PVO Child Survival Projects Ending in 1997 and a separate protocol developed by World Vision for the evaluation. (See Appendix V for the World Vision Final Evaluation Protocol.)

Evaluation results have already been shared with WVS staff, partners, and community members in a presentation by the Team Leader on September 30. This report will be distributed to former DUICSP staff and Area Development Program (ADP) Health Program Coordinators who in turn can share information from the report with CVs during monthly or bi-monthy meetings.

b. Main Achievements and Constraints of the Project

The most important achievements of the project, as identified by project staff as well as members of the Evaluation Team, are the following:

- Organizing and empowering the community (see Sections 4.b.2, 4.d., 5.c. 1);
- Decreasing morbidity in the community, including dehydration due to diarrhea, nightblindness, malnutrition, pregnancy complications, and vaccine-preventable diseases; and,
- Developing new and innovative methods and strategies (see Section 7.a) which can be used as a model for urban service delivery.

The most important general constraints which impeded the achievement of project objectives included:

- High rates of migration impeded the project in a number of ways. Those who migrated most frequently tended to be of high-risk. Project staff and volunteers experienced difficulties in following up on defaulters and others at risk. Measures of project impact were lower in areas with higher migration (see Section 5.b);
- There was gender bias against girls resulting in higher rates of malnutrition for girls. (Girls ate after other family members.);
- Early marriage, with women averaging less than 18 years of age at first marriage, contributed to pregnancy-related mortality; and,
- There was widespread poverty, poor environmental conditions, frequent natural disasters (e.g. flooding), and political instability in the area.

c. Main Conclusions for Capacity Building and Sustainability

The project has built capacity within the government, NGOs, and especially the community. Project staff participated in two GO/NGO Forums, one in each project area. Staff from NGOs were included in research activities, training events, seminars, and workshops. Health education materials, posters, and curricula were developed with the government for such interventions as AR1 and school health, and the Dhaka City Corporation (DCC) was included in operations research activities. Volunteers at all levels received basic and refresher training throughout the project, in addition to some training in specialized areas.

After the end of this final cycle of funding under BHR/PVC, impact within the project area will be sustained largely through four mechanisms:

- integration of child survival clinic services into two separate ADPs under the auspices of WVB;

- new clinic services to be implemented by two local NGOs, Unity Through Population Services (UTPS) in Mohammedpur and Population Services and Training Centre (PSTC) in Kamalapur;

- activities carried out through the strong and extensive community infrastructure developed and nurtured by WVB; and,

- learning on the part of individuals in the community.

The likelihood that project achievements will be sustained through these mechanisms is very high. The continued availability of funding for the ADPs, however, will be of utmost importance in sustaining project achievements. Also important will be the manner in which the ADPs involve the existing community structure, still to be determined.

d. Main Conclusions in Meeting Project Objectives

If card plus history is used for vaccination coverage, the project achieved the target for 13 of the 16 indicators being tracked (within a 10 percent confidence interval). This is impressive given the high mobility of the project area (about 30%). Most sustainability indicators, especially those pertaining to community involvement, were also reached. An exception was cost recovery which was negligible.

The DUICSP was particularly successful with regard to vaccination coverage. Measles coverage was 72 percent compared to only 58 percent full coverage for urban areas as a whole in the National Coverage Evaluation Survey Result (NCESR) for 1997. TT2 coverage for women was also quite high (74% for this urban slum area vs. 81% for urban areas in general in NCESR 1997).

Vitamin A coverage of children 12 to 71 months was impressive, estimated to be 95 percent according to Vitamin A capsule (VAC) administration records. The project documents a drop in reported nightblindness from two percent in 1988 to less than .Ol percent in June 1997.

There was a decrease from 1995 to 1997 in the number of deaths of children under 5 due to project-addressed causes relative to all other causes combined. Similarly, the number of deaths due to pregnancy-related causes was greater than for all other deaths to women 15-45 combined in 1995. In 1996 and 1997, after the DUICSP began antenataI/postnatal care, the number of deaths related to pregnancy was about half the number of deaths due to all other causes combined.

In addition to the quantitative achievements of the project, many qualitative achievements can be noted. The project:

- Created a very effective community organization to support it. This included five levels of volunteers; and,

- Developed innovations, new methods, strategies, and materials which were shared within and outside of Bangladesh.

e. Key Recommendations

Key recommendations include the following:

- In developing the ADPs, WVB should take advantage of the strong community organization formed under the DUICSP and appropriately link with established community groups, even without the benefit of health development workers. "Appropriate" linkage may involve more work with TBAs and FMGs, in keeping with the greater emphasis of ADPs on serving the poorest of the population. This may require an active role by WVB senior management in working with ADP Coordinators to develop an effective strategy;

- Health and education interventions under the ADPs should be integrated. WVB has experience in school health having developed and put into use curricula and health education materials for teachers and students, in conjunction with the Ministry of Health and Family Welfare (MOHFW) Health Education Bureau. It should build upon this experience by introducing health education into the schools within the ADP areas. Not only can this improve the health of school children, but younger siblings and other community members as well through the child-to-child approach. School children can be trained as community health promoters. Schools should also be involved in community-based surveillance, according to guidelines recently developed by WHO Bangladesh;

- The package of services offered by clinics under the ADP should be reevaluated by the Health Program Coordinator. The clinics are no longer operating under the mandate of a child survival and maternal health project. Community members are requesting new services, including reproductive health care, treatment for tuberculosis, and delivery services. PLA exercises should be conducted with the community to investigate areas where new health services may be needed;

- Service delivery protocols and standards for clinic services being developed under the QIP should be put into place by the Health Program Coordinator as soon as they are available. Until they are available, evaluators recommend the following specific steps should be taken to improve quality, based upon clinic visits:
  ♦ investigate ways to more evenly distribute the workload among public health

nurses (PHNs), perhaps with a study of patient flow. Patient flow may be improved if the PHN in charge of the Expanded Program on Immunization (EPI) treats some sick children; ♦ systematically screen all antenatal cases for diabetes as well as anemia during the first antenatal visit, ♦ develop a quality control instrument for health education delivered in clinic waiting rooms, and ♦ provide more training to clinic staff on family planning methods, their counter-indications, and side effects;

- The project should share lessons learned through multiple channels. This should include taking advantage of its links with the USAID-funded Quality Assurance Project (QIP) and could include publishing a series of monographs in such areas as: urban community development, child survival implementation, quality improvement, and surveillance and monitoring for impact. Development of the monograph series will require support from the regional and/or headquarters office. A television documentary could also be explored through WV/UK.

- WVB, with assistance from regional and headquarters offices, should seek funding for health services under the ADPs both to ensure continued funding throughout the life of the ADPs and to enable the programs to consider new services, such as the treatment of sexually transmitted diseases (STD), &cation for Acquired Immune-Deficiency Syndrome (AIDS), reproductive health services, and other services for which the community has a felt need. Former DUICSP staff may also be able to. provide technical assistance to staff of local NGOs under subcontract. [Note: Testing for AIDS by WVB is not recommended until the Government of Bangladesh (GOB) puts in place a national policy on AIDS. The draft national policy document endorses basic human rights for those testing HIV positive.];

- ADP Coordinators should clarify as soon as possible with volunteers from the community at all levels what support and/or linkages will remain with project staff during the design phase of the ADPs. (For example, can CVs be issued an identification card; will former DUICSP volunteers continue to receive free medical care; can oral rehydration salts (ORS) packets, Vitamin A capsules, and other supplies be obtained from the ADP clinics.); and,

- The ADP Health Program Coordinator and Program Monitor and MIS Support Officer should develop a simplified community-based information system which is realistic given the lack of health Community Development Workers (CDWs) for supervision of volunteers. For example, NHCs could be assisted in choosing a few critical indicators that can be ♦ visually represented, ♦ tracked regularly by themselves, ♦ result in action, and ♦ lead to improved health and decreased mortality of women and children. Most importantly, a basic HMIS and the well-functioning community-based disease surveillance (CBDS) system under DUICSP needs to be maintained under the ADPs.

2. Project Background

a. Initiation of BHWPVC-Funded Child Survival Activities

Child survival activities were first funded by BHR/PVC in Kamalapur (Ward 51) in October 1, 1988, just after a major flood occurred in the area. In October 1, 1991, BHR/PVC funding enabled WVB to combine child survival activities in the Kamalapur area with sponsorship-funded child survival activities in Mohammedpur (Wards 12, 13, and 14). This evaluation focuses upon the third of three phases of USAID funding, from October 1, 1994 to September 30, 1997.

b. Beneficiary Population, Interventions, Objectives, Planned Inputs, and outputs

Table A, Field Project Summary, and Table B, Project Goal and Objectives, taken from the Detailed Implementation Plan (DIP) submitted on March 31, 1995, provide an overview of the project (see following pages). As shown in Table A which follows, at the time the DIP was developed, there were an estimated 23,713 children five and under who were potential beneficiaries. From October 6 to November 10, 1996, a census was conducted in the impact area which provided more accurate and more recent population data. Table C (also following) shows the population of beneficiary target groups as of the 1996 census. At that time, the population of children five and under was 26,468, a 12 percent increase over the estimate in the DIP. Of these 26,468 children, 39 percent lived in slums, and two percent were "floating."

The major inputs, outputs, and measurement methods, as displayed in Table B of the DIP (following), have not changed. There are some discrepancies, however, between the objectives, as listed in Table B of the DIP and the objectives as listed in Section C.2 of the DIP, especially in the end-of-project targets. The objectives being tracked in the project HMIS which are displayed in Section 5 of this Final Evaluation report, are identical to those listed in Section C.2 of the original DIP.

DIP TABLE A: FIELD PROJECT SUMMARY

)/Country World Vision/Bangladesh Project Duration (mm/dd/yy): start date 10/01/94 estimated completion date 09/24/97

UDGET SUMMARY IN U.S. DOLLARS

(a) y year of project	(b) USAID Contribution (field + HQ)	(c) PVO Contribution (field + HQ)	(d) Total Contribution (field + HQ)
Year 1	$177,935	$151,982	$329,917
Year 2	$274,904	$58,255	$333,159
Year 3	$305,834	$28,157	$333,991
intry project total	$758,673	$238,394	$997,067

ercent of PVO Match 24%

(PVO Contribution divided by Total Contribution: sum of column "c" divided by the sum of column "d")

ERCENT OF TOTAL USAID CONTRIBUTION by INTERVENTION

ntages must add to 100%.

NTERVENTION	Percent of Project Effort (%)	Percent of USAID Funds in US $
mmunization	15	$113,801
ontrol of Diarrheal Diseases	10	$75,867
utrition	10	$75,867
itamin A	5	$37,934
dine		$0
ontrol of Pneumonia	10	$75,867
laternal Care/Family Planning	20	$151,735
lalaria Prevention & Management		$0
V/AIDs		$0
her (specify) (Capacity building)	15	$113,801
her (specify) (Partnering/Networking link)	15	$113,801
her (specify)		$0
her (specify)		$0
TOTAL	100%	$758,673

2. SIZE OF THE POTENTIAL BENEFICIARY POPULATION

Note: POTENTIAL BENEFICIARIES are defined as those in the project area who are eligible to receive services for a given intervention, not the percent you expect to provide services to - which may be smaller than the eligible population.

(e) a. Current population within each age group*		(f) Number of Potential Beneficiaries
infants, 0-11 months		4,996
children, 12-23 months		4,950
children, 24-59 months		13,767
children, 60-71 months	(If Vitamin A component)	5,790
females, 15-19 years	(high risk pregnancy)	10,512
females, 20-34 years		26,731
females, 35-49 years	(high risk pregnancy)	12,314
Other (specify)		
Other (specify)		
b. Additional births		
Total estimated live births, years 2 and 3		4,526
c. Total Potential Beneficiaries		83,586

* Note: Females (ages 15 - 49) should only be included as potential beneficiaries where they are direct beneficiaries of services (for example, TT immunizations, or family planning services), and not for educational interventions (for example, education on proper use of ORT).

4. CALCULATION OF USAID DOLLARS per BENEFICIARY per YEAR

a. Total USAID Contribution to Country Project (sum of column "b" in table 1, this page)	$758,673
b. Total Potential Beneficiaries (sum of column " f " in table 2, this page)	83,586
c. USAID Funding per Beneficiary for Project (line a. divided by line b. in table 4, this page)	$9.08
d. USAID Funding per Beneficiary per year (line c. above divided by 3 years)	$3.03

DIP TABLE B: PROJECT GOAL AND OBJECTIVES

PROJECT GOALS: To accelcratc reduction in mortality and morbidity in children under G years and in women I S-45 years of age.

PROJECT OBJECTIVE BY SEPT. 30, 1997	MEASUREMENT METHODS	MAJOR PLANNED INPUTS	0 UT PUTS	MEASUREMENT METHODS
70% of children 12-23 months will have rcccivcd full immunization coverage (cards) by age 12 months with BCG, DPT3, OPV3andMeasles vnccincs.	KPC Survey-Baseline, MTE & End of project.	I. Training course for project staff, NI IC members, CVs, FMGS and TBAs. 2. Maintain cold chain monitoring system. 3. Reinforce vaccination strategy. 4. NID (National Immunization Day).	I. Trained vaccinators and motivators. 2. Reliable cold chin. 3. Increased number of children vaccinated per scssiori.	I. Pre- and post- tests, training records 2. Monthly check on cold chain log. 3. Thirty clusldr EPI survey. 4. Domicilliary Visit Forms.
60% of mothers (I 5-45 years) will have rcccivcd 2 doses of tetanus toxoid vnccinc (card) before the birth of their youngest child less than 24 months of age.	Same as above	Same as above	I. Same as above 2. Same as above 3. Increased number of pregnant women vaccinated per session.	Same as above
60% of mothers (of children less than 24 months who dcsirc no more children in the ncxl 2 years or are not sure) are using modern contraceptive methods.		1. Contraceptive/condom distribution. 2. Social Marketing of Condoms. 3. Communication Materials.		I. Domicillinry Visil Form 2. Monthly reports
45% of mothers had at least 2 ante-natal visits (card) prior 10 the birth of her youngest child less than 24 months of age.	I. Pregnancy Registration/Follow-up Notebooks 2. KPC Surveys	1. Recruit 2 certified midwives. 2. Train & quip TBAs. 3. Develop & pre-test materials	1. Referral reports 2. High risk pregnancy and management	Supervisory checklist for TBA training

PROJECT OBJECTIVE	MEASUREMENT METHODS	MAJOR PLANNED INPUTS	OUTPUTS	MEASUREMENT METHODS
40% of deliveries in the last 12 months were attended by a trained person.	1. TBA Pictorial Report 2. KPC Surveys	1. TBA kits 2. IG 3. Tcclmical Assistance 4. Train TBAs in EOC referral.	Transportation for emergency obstetric care	
50% of mothers who delivered in die last 12 months would have received n card-documented vitamin A dose within 2 weeks after delivery	1. Pregnancy Registration Follow-up Nolcbook 2. KPC Survey	1. Administered high potency VAC 2. Breast feeding support 3. Nutrition education	Increased If of lactating mothers rcccivcd VAC.	Home-Based Card records, Diary & DVI'
90% of children 12-71 months would have rcccivcd nppropriulc doses of high potency vitamin A capsule (card) biannually.	Same as above	1. Administered high potency VAC 2. Nutrition education	1. Same as above 2. Increased % of children rcccivcd VAC	1. Same as above 2. Administered periodic VAC.
80% of mothers sought treatment for their infant/child (Icss than 24 months) with cough and rapid breathing in the past 2 weeks.	1. KPC - Baseline survey, MTE, & ECP survey	1, Train project staff, NI ICs, CVs. FMGs. 2. Develop health message. 3. Provide clinic-based treatment referral support as per WI IO Guidelines. 4. One IO one message disscminnlion and group health ctlucnlion	1. Trained CDWs, CVs. 2. Disscminnlion of appropriate message 3. Effective referral system 4. Pneumonia cases referred.	1. Pre- and post- test, training records 2. Check on monthly DVF, diary maintained by the CDWs and CVs. 3. Patients register 4. Follow-up cases 5. Referral slips
40% of infants less than 4 months are being cxclusivcly breastfed.	1. KPC - Baseline survey, MTE & EOP survey	1. Train project staff, NHCs, CVs, FMGs, TBAs. 2. Group health education/demonstration 3. One to one Nutrition message dissemination during DV.	1. Trained Project staff/CV/FMG/TBA. 2. Raised awareness. 3. Increased # of cxclusivcly breastfed infants/children. 4. Increased II of children appropriately weaned at ilppropriate time.	1. Pre- and post- test training records 2. Diary used by the projccl staff/CVs. 3. Exit interviews

PROJECT OBJECTIVE	MEASUREMENT METHODS	MAJOR PLANNED INPUTS	OUTPUTS	MEASUREMENT METHODS
50% of children wee 20 and 24 months, are sbet bre st feeding (and are being gitilh s lids/semi-solids). ive	Same as above	1. Kitchen garden promotion 2. Demonstration Nutrition Education Sessions 3. Weaning module	1. Trained mothers 2. Increased # of children continuously breastfed.	1. Growth monitoring. 2. Domicilliary visits
90% of infants/children ess than 24 months) with diarrhoea in last 2 weeks were treated with ORT.	Same as above	1. Train project staff, CVs, NECs, FMGs, ang TBAs. 2. One to one communications through DV. 3. Arrange group health education session at communit level.	1. Trained on disseminating hea essage on diarrhoeal mag h m ment. aget 2. Increased awareness of CRT practices	1. Pre- and post test training records 2. Analyzing ongoing data collection 3. Check diary of CDWs and CVs.
90% of infants/children ess th an 24 months) were given same amount or more breastmi	Same as above	1. ORT corners. 2. ORS packet distribution. 3. Nutrition education.	1. Improved nutritional status 2. Improved competency in knowing management of diarrhea	1. Focus group discussions. 2. Domicilliary Visits
80% of infants/ch ldren (less than 24 months) with diarrhoea in the last 2 weeks were given same amount or more food.	Same as above	Same as above	Same as above	Same as above
80% of infants/children(less than 24 months) with diarrhoea in the last 2 weeks were given the same amount or more fluids other than	Same as above	Same as above	Same as above	Same as above

Table C Demographic Information
Dhaka Urban Integrated Child Survival Project

Impact Area Kamlapur (Ward #30,84 and 85) and
Mohammedpur (Ward # 42,43,44,45 and 46)

Time Period: October 6 to November 10, 1996

A. Target Population	-Floating	Slum	Non-Slum	M+H class	Total
No. of family	907	17907	15354	21458	55626
No. of family member	3913	75188	65544	107559	252204
No. of target family	829	15666	12739	19765	48999
No. of target family member	3654	66876	54052	95801	220383
No. of Children (0- 11 months)	115	1932	1350	1536	4933
No. of Children (12-59 months)	479	8463	5633	6960	21535
No. of Children (60-7 1 months)	85	1772	1220	1670	4747
No. of Women (15-45 years)	896	18068	15749	29234	63947
No. of Pregnant Women	55	1097	609	620	2381
No. of early marriage couple <18 years	16	293	90	33	432
No. of elligible couple	727	14041	11259	16115	42142

B. Community Partners	Floating	Slum	Non-Slum	M+H "Class	Total
No. of Neighbourhood Health Committee	*1	*67	*111	*321	@94
No. of Community Volunteer (CV)	2	23	79	198	302
No. of Traditional Birth Attendant (TBA)	2	32	34	7	77
No. of Focus Mother Group (FMG)	3	41	25	1	69

* Number of NHC member is distributed in categories
@ Number of NHC(s)

C. Service Providers :	Floating	Slum	Non-Slum	M+H Class	Total
No. of NGOs	0	9	3	142	154
No. of Clubs	1	6	9	20	36
No. of Hospital/Clinic	0	0	3	50	53
No. of Dispensaries/Pharmacies	0	3	31	160	194
No. of Schools	1	18	10	93	122
No. of Garments	0	2	5	38	45
No. of Religious Centers	0	8	19	51	78

c. Project Site and Health Infrastructure and Services

The project was implemented in two geographic areas of Dhaka City, Bangladesh, with a combined population of 252,204, as of a 19% census, residing in eight densely-populated wards covering 13 sq. km. : Mohammedpur and Kamalapur. Mohammedpur, in the northwest of Dhaka City, contained Area A which was comprised of Wards 30, 84, and 85. Kamalapur, in the Southeast of Dhaka, was administratively divided into Area B with Wards 42, 43, and 44 and Area C containing Wards 45 and 46.

There have been no changes in the project site since the DIP. The only change since the proposal was the withdrawal of services from "Geneva Camp" to avoid duplication of services with Al-Falah Bangladesh, an NGO. Geneva Camp was an area of Mohammedpur with a population of approximately 18,000 urdu-speaking Bangladeshi nationals from Pakistan. This change in project site occurred on October 1, 1994 and was fully explained in the DIP.

DCC is responsible for government health services in Dhaka City. There is no fixed government health facility in the project area, but there are a number of private clinics, NGO clinics, traditional birth attendants, and homeopaths. Only WVB, however, has been providing integrated child survival and maternal services and in all eight wards. In addition to the services provided under DUICSP, WVB has been providing both preventive and curative heath services to approximately 3,600 families of sponsored children. (Sponsored children are generally school-aged.)

The DUICSP was designated by the EPI Directorate to coordinate all EPI activities for the project with the two respective zonal offices of DCC and Urban Operations Officers (UOOs) of the USAID-funded BASICS Project in Dhaka. Until preparing for phaseout during the final project year, DUICSP maintained a total of five fixed sites for immunization (two sessions/site/week) and a total of 12 outreach sites (once/month). Active continuous EPI surveillance in the project area began in March 1992 following a Disease Surveillance Workshop. The 12 outreach sites were phased out during the final project year, and three of the fixed sites were consolidated into one site.

In March 1997, in response to a recommendation of the Mid-Term Evaluation as well as interest by the community, DUICSP begin to offer integrated, "one-stop-shopping" service delivery with all services available during full-day clinics offerred at each of the fixed sites. In Mohammedpur, the clinic began with three fixed centers at the beginning of the project period. These were consolidated into one clinic with the "one-stop-shopping" model in March 1997. The one-stop service delivery model is displayed in Appendix VIII. Throughout the project period, two fixed clinics were maintained in Kamalapur.

The DUICSP regularly used a number of government and NGO referral sites nearby the project area.

d. Project Design and Collaboration with Other Organizations

The original project design to achieve the projects goals and objectives, as stated in the DIP, involved:

1. Extensive partnering and networking linkages between key private and public sector players aimed at promoting (a) technical synergism and integration; (b) congruence and program-sharing of like-minded PVOs/NGOs; (c) maximization of resources; (d) synthesis and coordination; (e) consistent Child Survival (CS) messages and strategies; and (f) sufficient resources and information to allow an informed choice of CS services linked to private sector referral networks.

2. Institutional-strengthening efforts calling for development of strong management, technical, and fund-raising skills within CCCs which represent a committed and sophisticated community infrastructure, facilitated by WV in the two impact areas. This capacity building will ensure the CCC's institutional, technical, and financial viability after project phaseover, allowing them to embrace eventual supervisory takeover, maintain high CS service coverage, sustain community demand for CS services, and effect CS behavioral change.

3. Deepening program quality by (a) developing and field-testing quality assurance instruments for assuring the quality and effectiveness of service delivery and supervision; (b) developing community-based surveillance for vaccine-preventable diseases to assess the effectiveness of the project's monitoring and evaluation system; (c) assessing the impact of knowledge of EPI program performance on immunization-seeking behavior; and (d) assessing the effectiveness of health education/social mobilization for antenatal care.

The project design remained unchanged at 'the time of the Final Evaluation, except that instead of four Ward Consortia, two CCCs were established.

At the time of the DIP, the following agreements for collaboration with other organizations were in place:

1. The EPI Directorate/EPI Zonal Office will provide EPI vaccines, cold chain equipment, trainers, EPI training materials and recurrent costs of cold chain maintenance in the eight wards.

2. The DCC Slum Development Project will second part-time staff to the project and dedicate a part of the community center to be used as a health center for the slum population of the project area.

3. The BASICS urban EPI project will absorb costs for orienting CCCs, NHCs, FMGs, CVs, TBAs, and local NGO and project staff in CBDS.

4. The MOHFW's AR1 program will shoulder training costs for clinic-based NGO/private sector physicians and project staff, cotrimoxizole supply, AR1 timers, four-color-coded cards to document the severity of pneumonia, and AR1 diagnosis/case management training manuals.

5. The IPHN has agreed to continue providing VAC capsules and nutrition education materials.

6. UNICEF will provide communications materials focusing on gender-biased behaviors and management training of CCC and NHC members.

7. Six staff from three clinic-based local NGOs will train the TBAs in providing fee-for-service, community-based antenatal care, clean delivery, and postnatal care. Training manuals for TBAs in antenatal care will be used.

8. Eight staff with income generation expertise from local NGOs/WVB sponsorship projects will be linked up to the CCC, NHCs, FMGs, and CVs' Central Association to provide technical assistance in income generation startup management and marketing.

9. The Urban Health Extension Project of the ICDDR,B will provide technical assistance in planning and implementing quality assurance monitoring in a joint "Applied Research on Environmental Health Project. "

10. SCF/UK has agreed to continue accepting referrals for nutritional rehabilitation of severely malnourished children.

Since the time of the DIP, four new partners have been added, as follows:

1. An agreement was secured from the Directorate General of Family Planning to provide family planning services in Ward 30 of Kamalapur.

2. A Street Girl Project was begun in Kamalapur, subsequent to a major research effort in 1993.

3. Most importantly, two ADPs were started by WVB, one in Mohammedpur and one in Kamalapur. These ADPs are of primary importance in ensuring the sustainability of project achievements.

4. The USAID-funded Quality Improvement Project (QIP) is assisting the project to disseminate lessons learned and to improve quality (see Section 6.b).

New potential partners are UTPS and PSTC.

3. Recommendations of the Mid-Term Evaluation

The Mid-Term Evaluation of the DUICSP was conducted from August 17-22, 1996. Following are the recommendations of the Mid-Term evaluation report, along with the responses.

No.	Recommendation	Response
1.	Project staff and client communities explore strategies to ensure the daily and simultaneous availability of treatment of illness, immunization, maternal care, and family planning at all facilities. Such a review will require an assessment of personnel and facilities to maximize use of resources. Provision of space to community for literacy training should be explored.	The project began to offer au integrated package of services in March 1997 at all times the three clinics being operated under DUICSP at the time of the Final Evaluation were open. This new, integrated strategy is being called "one-stop shopping." Staff were trained to deliver all appropriate services during each visit. For example, the vaccination status of mothers and children is checked when they come for other services. Health education is given while clients are waiting for services. The Project was not able to add literacy training during the final project year.
2.	Given the importance of fertility choice as a human right and the high attributable risk of poorly timed pregnancies (too early, too quick, too many, and too late) to neonatal infant and maternal mortality, the project explore options to increase access to family planning services. Project explore associating with an NGO providing quality family planning service to facilitate the expansion of the current package of services.	Subsequent to the Mid-Term Evaluation, staff in all clinics were trained to provide family planning counselling and appropriate referral. In addition, the project applied for and received registration from the Directorate General of Family Planning to provide family planning services in Ward 30 of Kamalapur. The project is now providing oral contraceptives and condoms in Ward 30.
3.	Project develop a continuing education curriculum for each set of monthly meetings using a 12-month calendar of major issues. Disease specific subjects should be linked to the epidemiological calendar, e.g. identification of measles susceptible 9-36 months (Oct.-Nov.); recognition referral and treatment of ARI/Pneumonia (Dec.-Jan.); orientation and treatment of diarrhoea (May-June).	The project has developed and circulated to clinic and field staff, as well as to community partners, an "epidemiological calendar" to address seasonally-appropriate interventions. During clinic visits, the final Evaluation Team found that health education sessions being conducted in the clinic waiting rooms were focussing upon the major problems of the season and of those present.

4.	Project utilize framework provided during the "Using Data to Improve Urban Health Workshop" to review current HMIS and place priority on systems for which meaningful information is being collected and used. Use data to identify high-risk areas for priority allocation of resources.	Staff have been trained at all levels to examine coverage data, prepared and presented graphically by the HMIS staff, to identify high-risk areas and to focus upon these. Action has been taken in the priority areas for pregnancy followup, immunization left outs and drop outs, and need-based counselling for family planning. A new data collection form was developed and used for high-risk areas. (See also response to Recommendation No. 6.) Staff had previously been trained to use registers to identify women aud children needing immunization or Vitamin A and women needing antenatal care.
5.	Project be commended for the progress being made in the collection of mortality data. Project utilize locally available technical assistance to upgrade staff and project understand@ of the value and use of verbal autopsy data at the community and program levels.	The project is now giving more emphasis to sharing community-based disease and death surveillance data and findings not only with volunteers but also with NGOs and the GOB. Staff have also received technical assistance from other NGOs to try to improve the completeness of data collection and analysis.
6.	Project review its current demands for data collection of CVs and CDWs and, if appropriate, modify procedures to reflect need, understandability, and use.	A comprehensive review and modification of the HMIS was conducted in May 1994. Upon further review, subsequent to the Mid-Term Evaluation, the project eliminated a home visit data collection form used by CVs and introduced a need-based data collection and reporting format for high-risk areas.
7.	Project management review the current use of the Nutrition Rehabilitation Unit in terms of impact and use of resources.	On reviewing the utilization of Nutrition Rehabilitation Unit (NRU) run by the project, it was found that the attendance was declining and that followup was difficult due to frequent migration. After discussion with the community, the NRU was discontinued.
8.	DUICSP implement the new EPI Guidelines for CBDS.	To address this recommendation, the project requested and received technical assistance from the MOHFW EPI Headquarters. The verbal autopsy form used by the project was subsequently revised to follow EPI guidelines.

9.	Project be commended on its ARI/Pneumonia collaboration with ICDDR/B. Project management meet with the Urban Health Extension Project to share project experience and to explore how the project can better use the "goldmine" (Sonar Khoni) of information available form urban research.	Several sharing sessions have been held with the MCH/FP project of 1CDDR.B to address this recommendation. This collaboration is on-going.
10.	That WVB: 1. recognize the development relevance of its current project to the future of urban health in Bangladesh. 2. reconstitute DUICSP as a local NGO so as to have access to funding. 3. explore bridge funding to ensure continuity untilnewfundingisonline. 4. explore opportunities for funding through the DCC and its Asian Development Bank (ADB) loan and the new USAID Urban Service Delivery Partnership (USDP) . 5. that it consider splitting the project with incorporation of the Mohammedpur project into the proposed Dhaka Urban ADP and the promotion of the Kamalapur segment for urban service delivery.	 1. The project has been disseminating lessons learned on an on-going basis through the NGO Forum, presentations, and reports. The project plans to prepare a document containing end-of-project lessons learned to disseminate both within Bangladesh and internationally. 2. The project has recently applied for registration as a local NGO. The application is pending with the GOB. 3. Several attempts were made to explore bridge funding both locally and internationally Vision Bangladesh. None was found. 4. Only local NGOs were funded under the USAID USDP. ADB funding will not be available for another year. WV may seek ADB funding at that time. 5. The project areas have been split, and some DUICSP activities are to be integrated into two separate ADPs. This final evaluation report details plans for the integration.
11.	The final evaluation of the DUICSP be designed to capture project achievements in terms of progress towards objectives, cost, and development relevance. Explore video documentation.	These issues have been be addressed in this final evaluation report.
12.	USAID acknowledge its privilege of partnership with DUICSP that it officially convey to the project and its community partners its admiration for its achievements, and it share this effective humanitarian empowerment use of foreign assistance with USAID-Washington.	The project has been providing and will continue to provide information to USAID which can be shared throughout the agency as well as within the larger development community.

4. Capacity Building and Sustainability

a. Relationship of the DUICSP to Other Health-Related Activities

The project has actively identified health service providers in its working area by conducting mini-surveys.

The coordination of EPI services with the EPI Directorate was explained in Section 2.c. In addition, the DUICSP regularly used a number of government and NGO referral sites within reach of the project area. These included the Telegu Community Clinic for diarrhea, Save the Children (SCF), WVB's Nutrition Rehabilitation Center (until it was closed subsequent to the Mid-Term Evaluation), the National Hospital for difficult deliveries, Shishu (Children's) Hospital, and the Islamia Eye Hospital. Referrals were made to the Women's Health Coalition Clinic, other NGO clinics, and government family planning centers for surgical sterilization and IUD insertion. Most nearby NGO referral sites are members of GO/NGO Forums attended by WVB staff.

At the time of the Final Evaluation, the USAID-Funded USDP had just awarded subgrants to two local NGOs to provide an Essential Services Package (ESP) in the areas served by the DUICSP. PSTC was awarded a subgrant to provide services in Karnalapur, and UTPS was awarded a subgrant for the Mohammedpur area. (See also Section 4.b. 1.)

The DUICSP also maintained a working relationship with TBAs and coordinated some activities with private practitioners.

b. Sustainability

After the end of this final cycle of funding under BHR/PVC, impact within the project area will be sustained largely through four mechanisms:

- integration of child survival clinic services into two separate ADPs under the auspices of WVB;
- new clinic services to be implemented by two local NGOs, UTPS in Mohammedpur and PSTC in Kamalapur;
- activities carried out through the strong and extensive community infrastructure developed and nurtured by WVB; and,
- learning on the part of individuals in the community.

b. 1 Integration of Clinic Services into ADPs

WVB has begun to implement new ADPs in both Moharnmedpur and Karnalapur. ADPs represent at least a lO-year commitment on the part of WVB to provide an integrated package of development interventions to residents of communities with sponsored children. The ADP package typically includes interventions in the areas of education and income-generation as well as health. ADPs can be structured to provide services to more than just sponsored children and can build upon the community organization developed under the DUICSP.

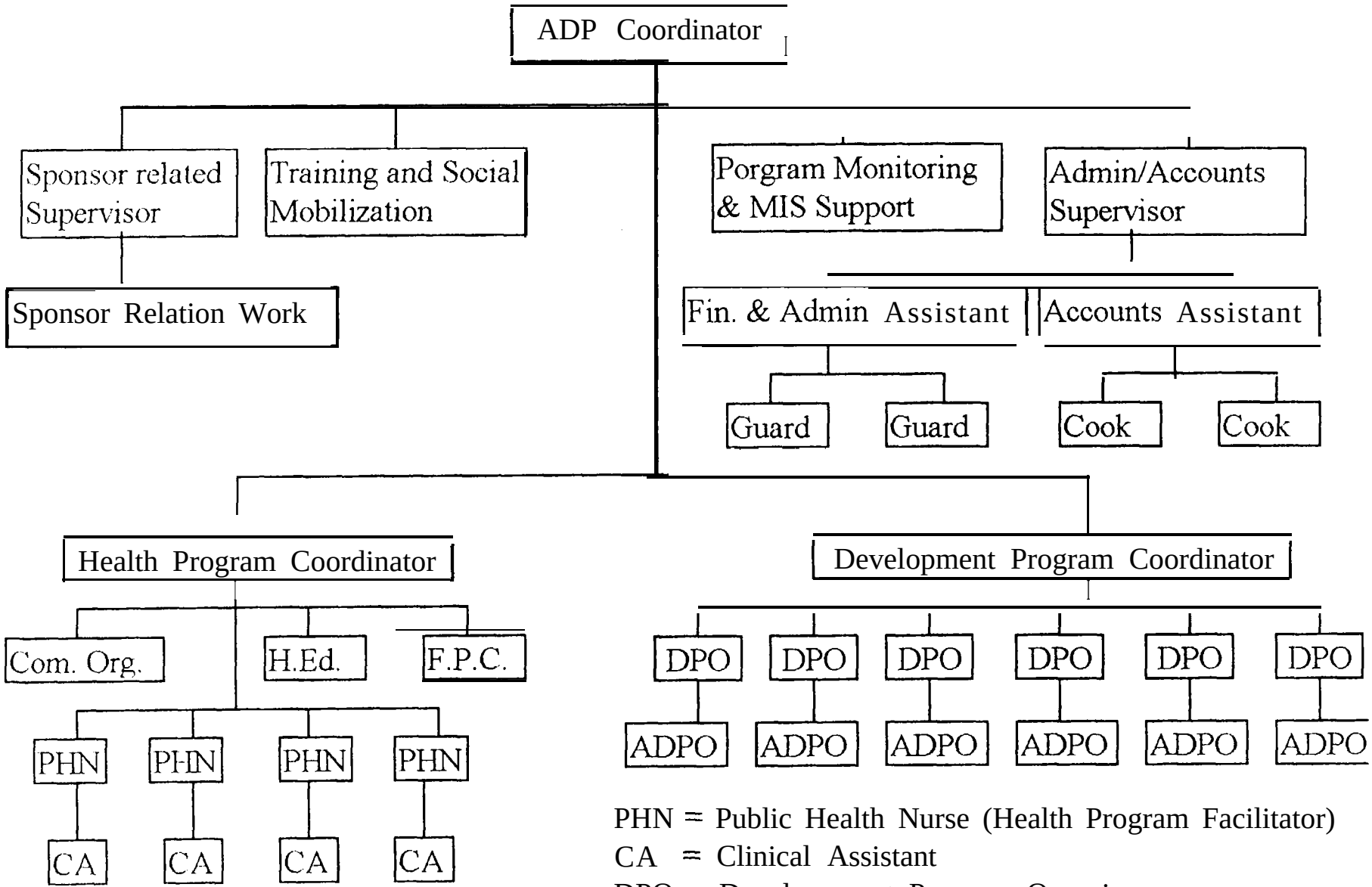
WVB is committed to continuing services in the three fixed-site clinics which were operating at the time USAID funding ended on September 30, 1997. A "phaseover" plan for the clinics was developed some months ago and is being implemented. The clinics remain open and continue to provide services to both sponsored children and their families as well as the target beneficiaries under the DUICSP.

In Mohammedpur, the ADP will have a fiscal year (FY) 1998 total budget of $296,798, $68,000 (22%) of which is earmarked for health. The basic package of clinic services under the DUICSP was estimated to cost $37,785 during the final project year. In Kamalapur, the total FY 1998 budget is $237,000, of which $56,818 (23%) is earmarked for health activities compared to a cost of $41,812 for essential clinic services during the final year of the DUICSP. The proposed budgets for health services under the ADPs, therefore, are sufficient to provide the basic package of clinic services provided under the DUICSP. (See Appendix IX for calculations of the annual cost of the "basic package of clinical services. ") In addition to the three clinics to be operated by WVB under the ADPs, there are plans to open two new satellite clinics, one in each ADP area.

There was no planned strategy in place at the time of the Final Evaluation, however, regarding how the ADPs would work with the existing community structure. The DUICSP staff worked closely with the community in phasing out the project, but there is no phase-in plan under the ADPs. ADPs typically have a lengthy development process at the beginning. Baseline surveys and PLA exercises are conducted in the community. Meanwhile, much of the strong community organization developed under DUICSP could be lost if linkages are not quickly reestablished.

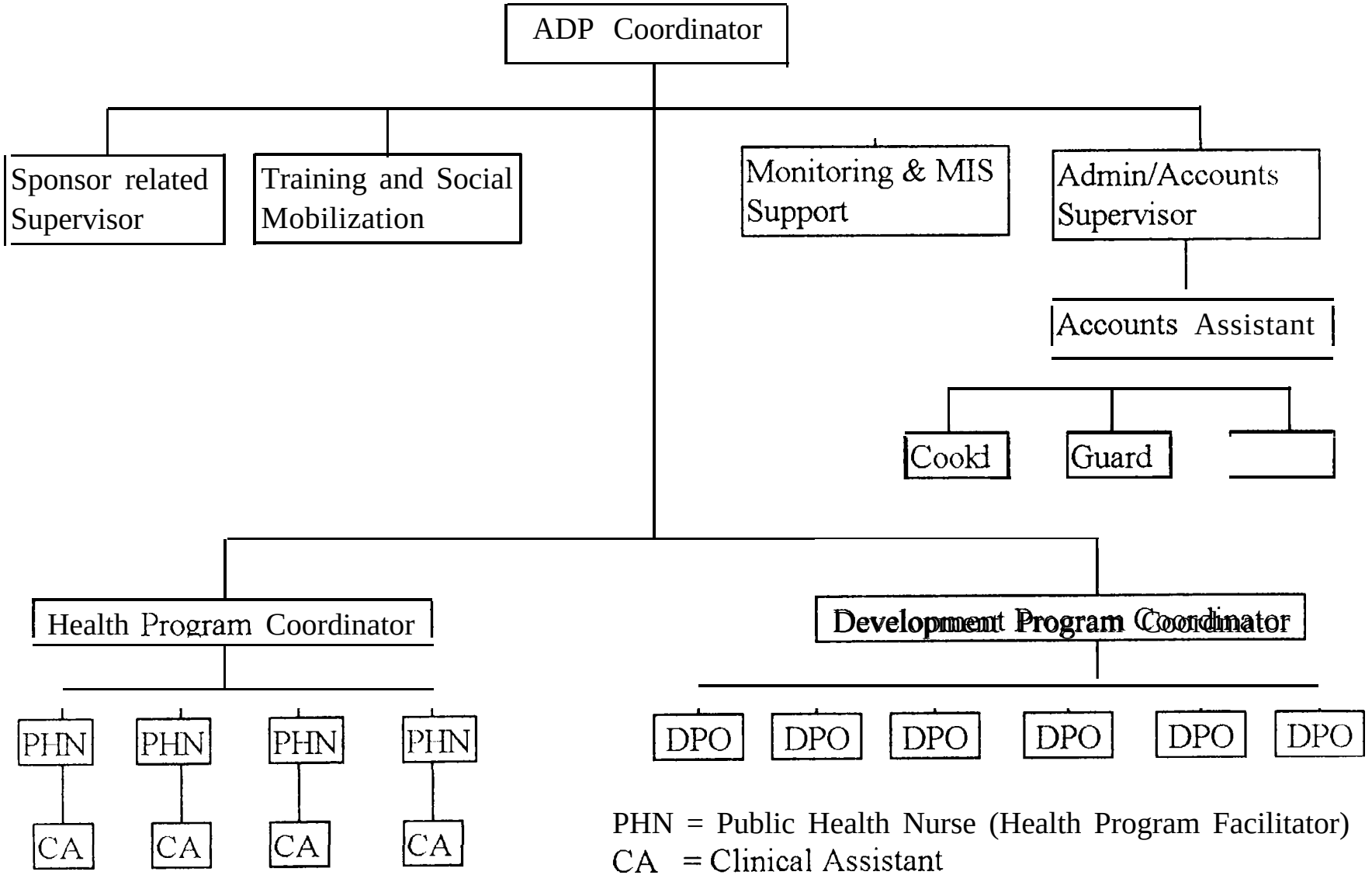
The following organizational charts of the two ADPs show the staffing pattern, including health services.

Mohammedpur Area Development Program



PHN = Public Health Nurse (Health Program Facilitator)
CA = Clinical Assistant
DPO = Developement Program Organiser

Kamalapur Area Development Program



PHN = Public Health Nurse (Health Program Facilitator)
CA = Clinical Assistant
DPO = Developement Program Organiser

b.2 Coordination with the USDP

As mentioned in Section 4.a, at the time of the Final Evaluation, subgrants had just been awarded to two local NGOs, UTPS in Moharnmedpur and PSTC in Kamalapur, to provide an ESP. The ESP contains all services which had been provided under the DUICSP. UTPS will be providing clinic services in Zones 6-7 of Dhaka. These zones contain the five wards in which the DUICSP has been working. UTPS plans to open three main clinics and six satellite clinics in the two zones. One main clinic and two satellites will be serving the DUICSP target population. The main clinic is now open, having been recently converted from a family planning clinic to a full-service clinic offering the ESP. The satellite clinics have yet to be established. PSTC was award a subgrant for Zone 1, Wards 30, 75, 84-86 and Zones 4-5 in Dhaka City. This area includes the three zones in Kamalapur served by the DUICSP. PSTC plans to have six clinics in its area, one of which is located nearby one of the two clinics of the DUICSP. This PSTC clinic was recently converted from a family planning clinic to a full-service clinic offering the ESP.

During the Final Evaluation, members of the Evaluation Team visited the headquarters offices of both UTPS and PSTC as well as the Kamalapur clinic operated by PSTC. UTPS has expressed an interest in comprehensive coordination of its clinic services with the WVB clinic to be operated under the ADP. Possibilities for coordination discussed in the meeting included technical coordination and referrals as well as decisions regarding where to locate the new satellites, and referral. PSTC was interested in technical coordination. Both UTPS and PSTC are strong in family planning service delivery but relatively weaker in child survival and maternal health services. WVB can serve these child survival and maternal health clients, when referred to its clinics, as well as provide technical assistance to UTPS and PSTC, as requested, to strengthen services in these areas. At the same time, WVB may refer family planning clients and take technical assistance from UTPS and PSTC in strengthening its family planning counselling in all clinics and family planning service delivery for Ward 30.

b.3 Community Organization

Through the DUICSP, WVB has created a strong community organization. Many of the project activities were phased over to the community. For example, the community can now contact the DCC directly and organize its participation in VAC administration and National Immunization Days (NIDs). CVs are now doing all home visits, and many plan to continue doing so. The community organization and the capabilities of the community are described in detail in other sections of this report (see Sections 4.c and 4.d).

b.4 Individual Learning in the Community

Results of the 30cluster survey demonstrate significant learning and behavior change in the community. This learning will remain with the families assisted for some time to come, whether or not they migrate from the area, and many will undoubtedly spread their new learnings to other community members.

c. Increasing the Capacity of Local Partners

Throughout phase three of the project, meetings were held with NGO partners and the community to increase their capacity. Project staff participated in two GO/NGO Forums, one in each project area. Staff from NGOs were included in research activities, training events, seminars, and workshops. Health education materials, posters, and curricula were developed with the government for such interventions as AR1 and school health, and the DCC was included in operations research activities.

"Training will be the main capital," CCC Member, September 27 interview.

Volunteers at all levels received basic and refresher training throughout the project. In addition to basic and refresher training:

- Members of the CCCs and NHCs received training in management, fund raising, and community mobilization at PROSHIKA, a local NGO, sponsored by WVB.

- Some CVs received training on establishing cooperatives, peoples' theater, the HMIS, and producing a newsletter.

Volunteers at every level stated in interviews with members of the Evaluation Team that they were now able and intended to continue some activities after phaseout of the project. CCCs and NHCs felt that they could continue monthly meetings with CVs, members of FMGs, and TBAs to monitor their work and assist with problems. Although some members of the CCCs felt that they would also be able to recruit and train new volunteers to replace those leaving, the DUICSP staff and evaluators felt that training would be beyond their capabilities in most cases. CCCs felt equipped to continue working with the government in NIDs to increase vaccination coverage and Vitamin A distribution. All felt confident that they could liaison with the DCC directly as well as organize and supervise volunteers for the NIDs without support from project staff.

In 1995, the project gradually began to transfer the task of home visits from CDWs to CVs in preparation for phaseout of the project. CVs were at first asked to conducted 30 percent of home visits. This proportion was gradually increased to 100 by the end of the project in September 1997. Initially, CVs resented making home visits on a voluntary basis as CDWs had been paid for the same activity. Project staff overcame the problem by organizing exposure visits to other child survival projects, providing technical assistance in organizing savings groups, providing free medical care for CVs, and sponsoring competitions. At the time of the Final Evaluation, CVs interviewed by members of the Evaluation Team were making all home visits. They stated that they were not finding the visits to be a burden and that they intended to continue home visits and health education in the community after project phaseout, with the support of the NHCs and CCCs. They did have concerns about whether their credibility in the community would drop without the institutional affiliation which the DUICSP had provided.

DCC does not have the capacity to take over any new project activities. It can now, however, work directly with the community in VAC administration and NIDs.

d. Community Participation and Mobilization

"We ***participated very intimately in every step,*** " CCC Member, September 27 interview.

Members of the community were involved in the design, implementation, and evaluation of the project.

Many of the volunteers interviewed by the evaluation team reported that they had been involved with the project since the beginning and that they had participated in its design. Some of the ways in which they had participated included advising the project regarding setting fees, interest of the community in particular interventions, and on the roles and duties of volunteers.

The community and volunteers at every level have been very active in the implementation of the project.

Members of the two CCCs report that they work an average of lo-12 hours a month. Their responsibilities include, in conjunction with members of NHCs:

- Holding a bi-monthly meeting;
- Supervising volunteers;
- Assisting in organizing monthly health education sessions;
- Reviewing NHC performance; and,
- Addressing environmental health hazards in the area. This has included contributing funds for sanitation, dust bins, and kitchen gardening.

Responsibilities of the members of the 91 NHCs include:

- Meeting monthly;
- Identifying health hazards in the community and suggesting solutions;
- Recruiting CVs and supervising their work;
- Supervising FMGs and TBAs;
- Encouraging the community to participate in events;

- Organizing and participating in special events, such as NIDs;
- Assisting volunteers at all levels in overcoming problems in the community;
- Assisting in times of natural disasters, such as helping to distribute water purification tablets and ORS during floods;
- Participating in monthly meetings with volunteers at all levels; and,
- Advising project staff on fee schedules.

The 295 currently active CVs spend about five to seven hours a week in their community work and have the following responsibilities:

- Attending monthly meetings. During these meetings, they submit a monthly activity report to NHCs and review and analyze the progress of activities;
- Participating in the biannual VAC distribution program and NIDs;
- Organizing immunization outreach sessions, until such sessions were phased out;
- Participating in social mobilization campaigns, including distribution of IEC materials, organizing street theater, and group health education sessions;
- Conducting all home visits. During home visits, they provide education in all of the project interventions; and,
- Participating in the CVs Cooperative.

A total of 56 TBAs meet monthly and have the following duties:

- Identifying pregnant women and referring them for antenatal care and TT vaccination;
- Helping pregnant mothers to have a safe delivery, including identifying the need for referral and assisting mothers to reach referral sites during obstetric emergencies; and,
- a Submitting a pictorial report to members of the NHCs during a monthly meeting.

Members of 69 FMGs spend about three hours a week on project activities. Their duties include:

- Participating in monthly meetings;
- Disseminating health messages in the community to nearby families and in small groups;
- Referring mothers for services, especially EPI;
- Identifying mothers and children at special risk;
- Reporting information during monthly meetings to members of the NHCs; and,
- Participating in savings/cooperative groups.

Volunteers have assisted in the monitoring and evaluation of project activities since the beginning. During the final evaluation, volunteers at all levels participated in interviews with members of the Evaluation Team and organized and attended events associated with project phaseout. Members of the CCC attended the final presentation of results of the evaluation.

In addition, there were two community representatives who participated fully in all aspects of the evaluation as members of the evaluation team. Each representative conducted a PLA exercise in their respective communities (one in Mohammedpur and one in Kamalapur). Their reports are included in Appendix IV. The reports of the PLA exercises indicate that most of the slum mothers who participated had heard of the project and its activities. They reported the services which they had received, how they knew about the project, and the changes that they had noticed in the community which they attributed to the work of the volunteers as well as staff on the project. These changes included a decrease in nightblindness and in vaccine-preventable diseases as well as in diarrhea and pneumonia. It is interesting to note that one group felt the Focus Mothers were most responsible for changes they had observed in the community.

All community members interview by the Evaluation Team stated that they felt the project had been successful and effective and that they wanted it to continue. Each community area (Mohammedpur and Kamalapur) organized and financed a farewell ceremony in their communities. Members of the evaluation team attended the ceremony in Mohammedpur, and the Team Leader participated as guest speaker. It was attended by approximately 300 community members. Many members of the community spoke about the success of the program and what participation in the project had meant to them personally. The community presented the WVB staff with a written statement of its appreciation (see Appendix VI).

*"The **project** has **given me dignity,** "* Focus Mother, Kalampur Farewell Ceremony, Sept. 26

e. Cost Recovery

Fees for service were first introduced as a method of cost recovery in 1992. Project beneficiaries were willing to pay for services as long as charges were discussed with the community and kept affordable. As no client was refused services for lack of payment and their was wide community acceptance of the fees charged, the Evaluation Team did not feel that the fees resulted in any lack of equity.

Initially Tk. 3 was charged in 1992 for treatment of minor ailments. The charge was later raised to Tk. 5 per visit. In March 1996, the fee was again raised to Tk. 10 per visit. In December 1995, a fee of 20 Tk. for an initial prenatal care visit and registration was introduced, with a fee of 10 Tk. for subsequent visits. Tk. 3 is charged for a vaccination card.

The total amount of money recovered during the final three years of the project was just under $10,000. (This can be compared to a very ambitious objective of 30 percent recovery of recurrent costs.) It is, however, unrealistic to expect the project to be able to recover a significant amount of the cost of service from a population with a high proportion of slum residents. The effort required to collect fees cannot be justified on the basis of recovering costs. Rather, the value of the service fees lies more in instilling within the community the concept that the services offered have value, in increasing the retention of child immunization and maternal cards, and in increasing expectations within the community of quality services. ("Nothing of value is free.")

f. Capacity Building and Sustainability Indicators

The DUICSP has been tracking the following sustainability indicators since the DIP:

Sustainability Objectives	End-of-Project Target	End-of-Project Achievement
Community Involvement		
NHCs formed and functioning	1 0 0	91
CCCs formed and functioning	2	2
Savings cooperatives of CV formed and functioning	2	4
CVs trained and functioning	350	295
CVs trained on Savings Cooperative account keeping and functioning	20	48

Community organizers under DC Slum Development Project have been trained on CS interventions and functioning	20	20
Income generation schemes initiated through CVs/TBAs	3	3
CCC members trained and have management, technical, fundraising, and community mobilization skills	40	47
Managerial		
Trained CVs working in credit and cooperative societies as active members	210	182
NHCs functioning actively in their working areas	60	91
Central committees of Kamalapur and Mohammedpur play a significant role in containing 30% of program interventions	30%	NA
Local NGOs provide 20% of service delivery for different interventions	20%	NA
Technical		
Trained TBAs are actively involved in identifying and providing services to pregnant women and referrals for critical obstetric care.	52	56
Financial		
Trained and functioning CVs are involved in income-generating activities	52	56
Recurrent service costs are being covered through cost recovery	30%	>1%

As can be seen from the table, the project has achieved nearly all of the sustainabihty targets, with the exception of cost recovery. The project has been particularly successful in meeting targets for community involvement.

g. Income Generation

Income generation is a felt need in the community. During interviews conducted in the community during the Final Evaluation, income generation was frequently mentioned by all volunteer groups as one of the DUICSP interventions which they would like to see expanded.

The project organized training for some volunteers on the management of cooperative societies and credit, bookkeeping, and management. Technical assistance was also provided by the Cooperative Credit Union League of Bangladesh (CCULB).

The following income generation activities were initiated during the project:

- A Neighborhood Cooperative Store was pilot tested by CCC in Kamalapur. Rice was purchased from a wholesale market and resold at the store at a lower price than in the market. The price charged was meant to be sufficient for a small profit after covering the expenses of a CV and day laborer to work in the store. The store was very popular, but failed due to management problems. Community managers were inexperienced and sometimes let community members (up to 60 %) take the rice on credit. Many of these accounts were not paid.

- A Handicraft Education and Marketing Association (HEMA) was formed by members of an NHC. They started a sewing training program for CVs, TBAs, and members of FMGs. The cost of the six-month training course was to be recovered by selling handicrafts. Many of the handicrafts did not sell, however, due to variable quality and lack of marketing knowledge.

- The Survival Association of Community Volunteers (SAW) was began in Mohammedpur by CVs who ran a seasonal business supplying essential commodities to local restaurants with a small profit (approximate Tk. 9,OQO during phase three of the project). Group savings were used as capital for this business. In addition to providing a small income for CVs, the association helped them to develop management skills.

In spite of some failures in generating income, community members interviewed were not discouraged. They felt that they had learned from mistakes and by subsequent training organized by WVB and were eager to try new ventures. The DUICSP staff felt that income generating efforts might be more successful if targeted toward those of lower income, e.g. FMGs and TBAs.

Despite community interest, however, there remain few, if any, successful models of income generation in urban slum settings in Bangladesh. If WVB is able to develop even a moderately successful model under the new ADPs, the results will have rapid acceptability and applicability nationwide.

5. Presentation and Discussion of Final Survey Findings

a. Comparison of 1994 Baseline and 1997 Final Survey Data

The following table contains the objectives and end-of-project targets, as described in the DIP. The table displays data from the baseline survey conducted in October 1994 compared to the final survey conducted in August 1997. Thus, the table shows the achievement of phase three of the project.

Dhaka Urban Integrated Child Survival Project (DUICSP)
Comparison of 1994 Baseline and 1997 Final Survey Data
by Project Objective

No.	Objectives	Survey Results	
		Baseline (10/94)	Final (8/97)
Immunization			
01.	70% of children (12-23 months) will have received full immunization coverage (card) by age 12 months with BCG, DPT3, OPV3 and Measles vaccines.	51% (N=70; D= 137)	49% (N= 103; D=210) 72% (N=150; D=210) (Card + History)
02.	60% of mothers (15-45 years) will have received two doses of TT vaccine (card) before the birth of her youngest child less than 24 months of age.	40% (N= 120; D=300)	32% (N= 136; D=420) 74% (N=312; D=420) (Card+History)
Maternal Care and Family Planning			
03.	60% of mothers of children less than 24 months who desire no more children in the next two years, or are not sure, will be using a modern contraceptive method.	50% (N= 137; D=273)	60% (N=234; D=388)

04.	40% of mothers will have had at least two antenatal visits (card) prior to the birth of her youngest child less than 24 months of age.	33% (N=98; D=300)	30% (N=124; D=420) 64% (N=270; D=420 (Card+History)
05.	45 % of deliveries in the last 12 months would have been attended by a trained person.	77% (N=231; D=300)	48% (N=lOO; D=210)
06.	50% of mothers who delivered in the last 12 months would have received a carddocumented Vitamin A dose within two weeks after delivery.	0%	23% (N=49; D=210) (Card+History)
Acute Lower Respiratory Infections (ALRI)/Pneumonia			
07.	50% of mothers sought treatment for their infant/child (less than 24 months) with cough and rapid breathing in the past two weeks.	60% (N=18; D=30)	79% (N=23; D=29)
Nutritional Improvement			
08.	70 % of children 12-71 months would have received appropriate doses of high-potency Vitamin A capsules (card) bi-annually.	NA	95x*
09.	60% of children less than 12 months would have received appropriate card-documented doses of Vitamin A at each EPI.	14% (N=23; D=163)	58% (N=123; D=210) 63% (N=133; D=210) (Card + History)
10.	80% of infants less than four months are being exclusively breastfed.	25% (N= 16; D=64)	18% (N=14; D=80)
11.	85% of children between 5 and 9 months, are being given solid or semi-solid foods.	80% (N=34; D=42)	83% (N=74; D=89)
12.	85 % of children between 20 and 24 months, are still breastfeeding (and are being given solid or semi-solid foods).	41% (N= 16; D=39)	82% (N=49; D=60)

Control of Diarrheal Diseases (CDD)			
13.	90% of infants/children less than 24 months of age with diarrhea in the last two weeks were treated with oral rehydration therapy (ORT).	80% (N=32; D=40)	88% (N=45; D=51)
14.	75% of infants/children less than 24 months of age with diarrhea in the last two weeks were given the same amount or more breastmilk.	88% (N=35; D=40)	72% (N=37; D=51)
15.	75% of infants/children less than 24 months of age with diarrhea in the last two weeks were given the same amount or more food.	55% (N=22; D=40)	49% (N=25; D=51)
16.	75% of infants/children less than 24 months of age with diarrhea in the last two weeks were given the same amount or more fluids other than breastmilk.	75% (N=30; D=40)	76% (N=39; D=51)

*Source: Bi-annual VAC administration records. The target age group is children 12-71 months. Respondents to the survey were mothers of children 23 months of age or less.

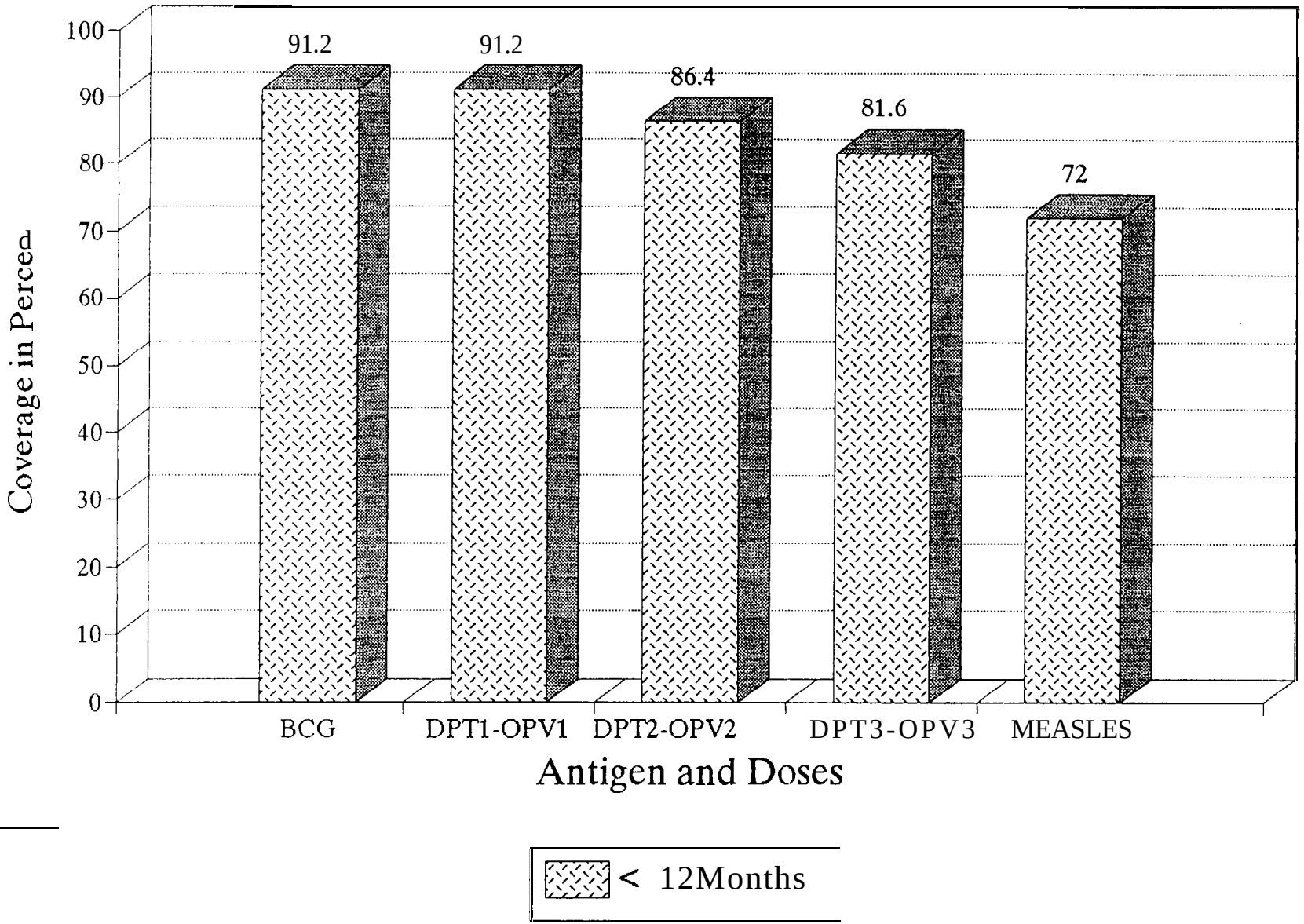
b. Discussion of the Results of the Final Survey

If card plus history is used for vaccination coverage, the project achieved the target for 13 of the 16 indicators being tracked (within a 10 percent confidence interval). Given the high mobility of the population and thus the great likelihood of losing vaccination cards, the evaluation team felt it was reasonable to consider reported vaccinations as well as card-*documented coverage in determining whether or not targets had been achieved.

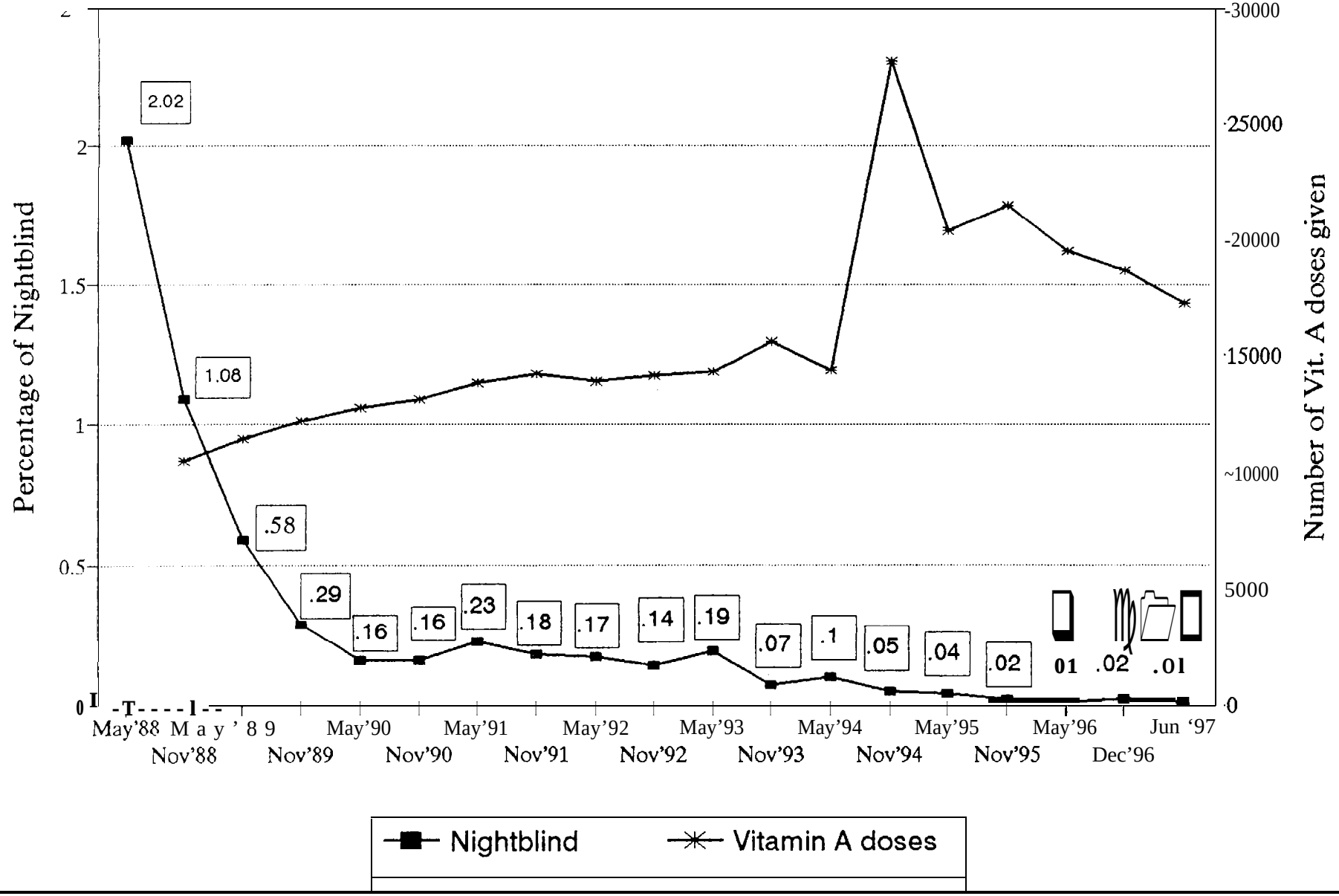
The DUICSP was seen to be particularly successful with regard to vaccination coverage. The bar chart on the following page indicates coverage of children under two by their 12th birthday (card plus history) for each of the six EPI antigens. Measles coverage was 72 percent, used as a proxy measure for full vaccination coverage. This can be compared to only 58 percent full coverage for urban areas as a whole in the National Coverage Evaluation Survey Results (NCESR) for 1997. The dropout rate from DPTl to DPT3 for the DUICSP area was less than 10 percent. TT2 coverage for women was high (74% for this urban slum area vs. 81% for urban areas in general in NCESR 1997).

Vitamin A coverage of children 12 to 71 months was also quite impressive, estimated to be 95 percent according to VAC administration records. The line chart which follows shows the drop in reported nightblindness from two percent in 1988 to less than .Ol percent in June 1997 compared to the number of Vitamin A capsules distributed. (Note: The sharp peak in VAC distribution in November 1994 coincides with a major NID.)

EPI Coverage - 1997 KPC Survey
Dhaka Urban Integrated CS Project



Night Blindness Prevention
Dhaka Urban Integrated Child Survival Project
Vitamin A Distribution and Night Blindness Cases



The three targets which were not met were:

- 50% of mothers who delivered in the last 12 months would have received a card-documented Vitamin A dose within two weeks after delivery. (23 % achievement)

  Only those mothers who were delivered by TBAs working with the project or who came to a project clinic for antenatal care could be given a Vitamin A dose within two weeks after delivery. Home visits were made only every six months (every 10 months toward the end of the project).

- 80% of infants less than four months are being exclusively breastfed. (18% achievement)

  Exclusive breastfeeding by women in the project area appears to be culturally alien. Those members of FMGs interviewed by the Team Leader of the Final Evaluation interpreted exclusive breastfeeding to mean the lack of bottle feeding. Honey, water, and other foods/liquids are given to infants almost from birth, along with breastmilk. Such deeply entrenched attitudes are difficult to change. The 80 percent target is unrealistic.

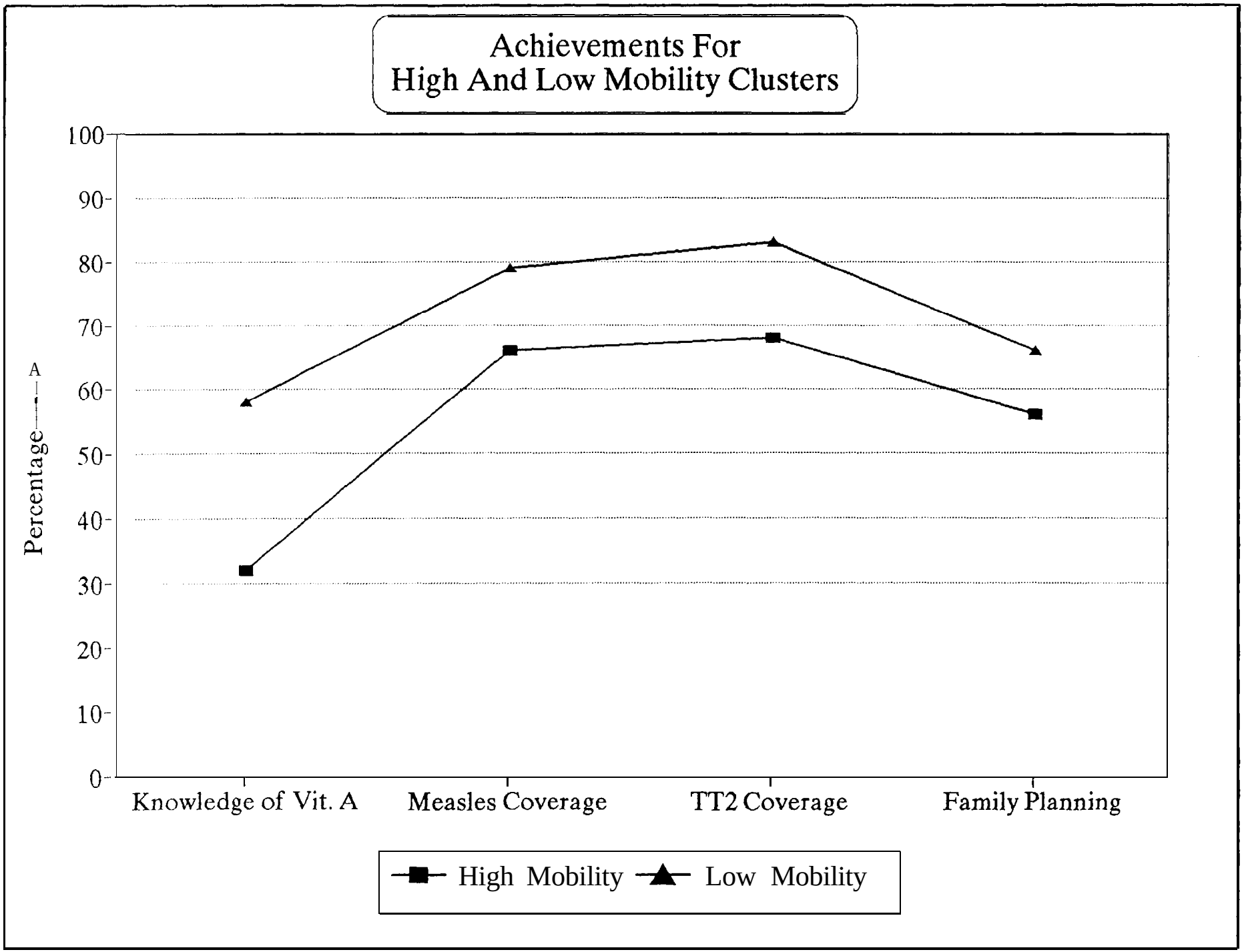
- 75% of infants/children less than 24 months of age with diarrhea in the last two weeks were given the same amount or more food. (49% achievement)

  Although appropriate feeding after diarrhea did not approach the target, the percentage feeding more or the same amount of food remained stable throughout the last three years of the project. ORT was a mature intervention beginning the first year of the nine year project. Those mother's whose attitudes could be more easily changed would have begun appropriate feeding long before. Further behavioral changes with regard to a mature intervention are difficult to achieve. Focus groups conducted early in the project found that many mothers would not feed their children with diarrhea more because they considered it to be a waste of food.

  The project did reach its targets regarding mothers who gave more breastmilk and other fluids during diarrhea. Measures of these indicators also remained stable during phase three of the project, however, with no further change in behavior found during the final three years of the project.

Given the high mobility in the project area, estimated to be 30 percent annually, the Evaluation Team was interested in the effect of mobility upon the achievement of project targets. As data were not available on the length of residence in the community of survey respondents, project staff were asked to rate each of the 30 clusters as "high mobility" or "low mobility." Of the 30 clusters, 17 were considered to be "high mobility" and 13 were rated "low mobility."

The following table displays the achievement for four key knowledge and practice variables surveyed by mobility status for the cluster. As can be seen, knowledge that Vitamin A prevents nightblindness was nearly double for respondents who lived in low-mobility clusters compared to high-mobility clusters (58% vs. 32%). Measles coverage, TT2 coverage, and use of modem methods of family planning were each about 10 percent higher in low-mobility clusters. High mobility, therefore, is a strong constraint in achieving and maintaining project impact.


Achievements For
High And Low Mobility Clusters
100
90
80
70
60
50
40
30
20
10
0
Percentage——A
Knowledge of Vit. A
Measles Coverage
TT2 Coverage
Family Planning
High Mobility
Low Mobility

C. Other Achievements

c. 1 Quantitative Achievements

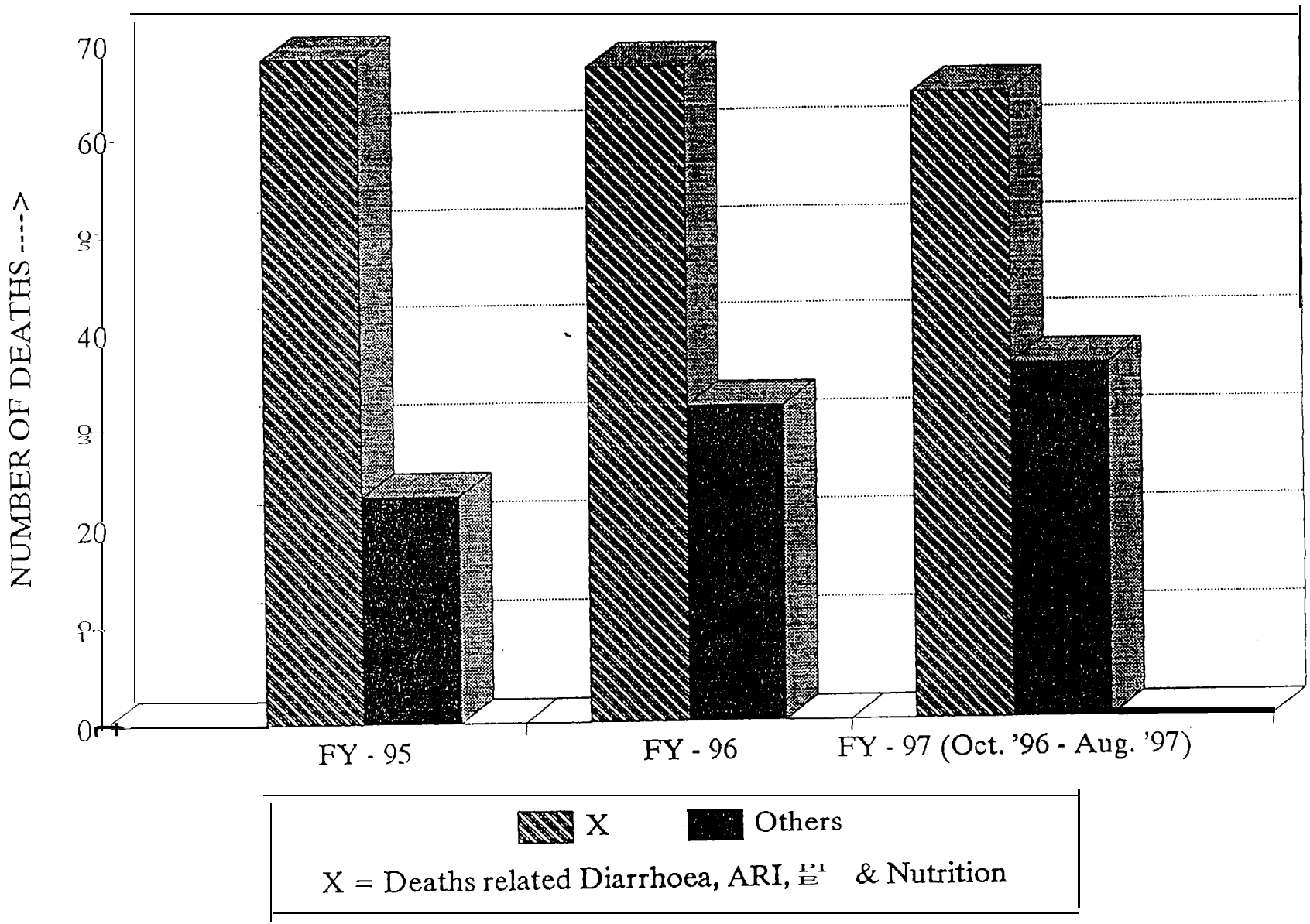
As the Mid-Term Evaluation found that the reporting of deaths is substantially incomplete, the number of deaths of children under five and of women of child-bearing age cannot be compared over the last three years of the project to determine impact upon mortality. Unless there are strong biases in reporting by cause of death, however, a meaningful comparison can be made by examining the relative proportion of deaths which resulted from causes addressed by the project and causes outside the mandate of the project.

The bar chart on the following page indicates the number of deaths of children under 5 due to diarrhea, ALRI, EPI, and malnutrition compared to **all** other causes of deaths. As can be seen, there is a slight decrease from 1995 to 1997 in the number of deaths due to project-addressed causes while the number due to **all** other causes combined increases.

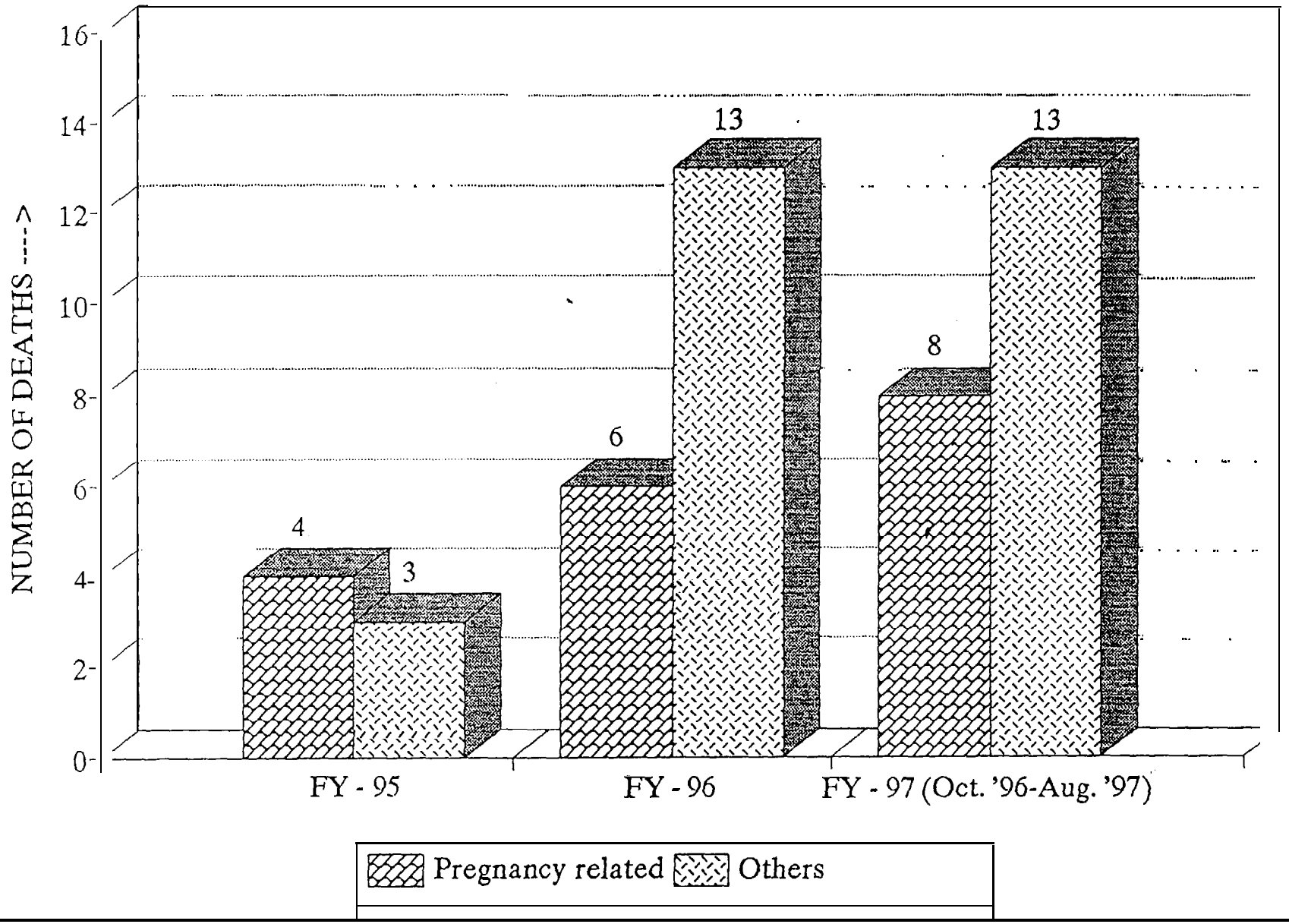
Also following is a similar table which compares the number of deaths to women 1545 years due to pregnancy-related causes and **all** other causes. In interpreting this table, it is important to note that **antenatal** and postnatal services began under the DUICSP in 1996. As shown, the number of deaths due to pregnancy-related causes was greater than for all other deaths combined in 1995. In 1996 and 1997, after the DUICSP began **antenatal/postnatal** care, the number of deaths related to pregnancy was about half the number of deaths due to all other causes combined. These data must be interpreted cautiously as the numbers are very small. The data do, however, suggest an impact upon mortality.

A summary table of service statistics, other than deaths, contained in the HMIS is included in Appendix VII. The table shows treatment visits, by type and year for phase three of the project. Clinic visits were somewhat lower in 1996 and 1997 compared to 1995. The clinics had to be closed for about 10 weeks in 1996 due to political disturbances (long hattels). In 1997, outreach sites were being closed out and the three clinics in Mohammedpur were consolidated into one in preparation for project phaseout. (Also note that 1997 data are for 11 months **only** as data for September was not available at the time of the Final Evaluation.) The data do indicate that the clinics were very active during the three years of the project, and that the numbers served did not decrease substantially after consolidating the Mohammedpur clinics.

COMPARATIVE DEATHS OF <5 CHILDREN
DHAKA URBAN INTEGRATED CS PROJECT



COMPARATIVE DEATHS OF 15-45 YEARS WOMEN
DHAKA URBAN INTEGRATED CS PROJECT



c.2 Qualitative Achievements

In addition to the quantitative achievements of the project, many qualitative achievements can be noted. Most important among these, the project:

- Created a very effective community organization to support it. This included five levels of volunteers: two CCCs, 91 NHCs, 295 CVs, 69 FMGs, and 56 TBAs; and,
- Developed innovations, new methods, strategies, and materials (see Section 7.a) which were shared within and outside of Bangladesh.

6. Issues Identified by Evaluation Team, Project, or PVO

Following are priority questions identified by stakeholders of the Final Evaluation along with responses:

Stakeholder	Question	Response
USAID	Will discontinuing home visits reduce the impact of project interventions?	This question can only be answered after some time has passed as support and close supervision of CVs who have been making home visits under the DUICSP has only just been discontinued. Some CVs stated in interviews that they would continue making home visits even with reduced support from WVB Staff. In a visit to the PSTC clinic in Kamalapur, however, clinic staff estimated that clinic visits have been reduced by one fourth since community-based services have stopped.
	How can community-based surveillance be continued?	CBDS may be continued with members of the CCCs and NHCs playing a greater role in supervising CVs, FMGs, and TBAs. The use of school teachers and children in CBDS may also be introduced.

	What will be the linkages with the GOB, other NGOs, and the community?	The linkages with the GOB, especially DCC, under the ADPs should remain basically the same. There will be stronger direct linkages between the GOB and the community, including the CCCs and NHCs. Linkages with the ARI and EPI Directorates will continue. Liiges will continue with NGOs through participation in the GO/NGO Forums. New linkages will be formed with USDP subgrantees. Linkages with the existing community organization under the ADPs have yet to be worked out; most likely linkages will be stronger with FMGs and TBAs but less strong with CVs, NHCs, and CCCs.
GOB	Can WV train GOB field workers?	Some training can be given to GOB field workers upon request by the GOB. The feasibility of each request must be evaluated.
	What is the model for urban service delivery? • Process: How to deliver services • Technical: content/ quality • Organizational Structure Cost Recovery	The process, technical content and quality, and organizational structure to support service delivery under the DUICSP has been extensively described in the DIP and First Armual Report and can be made available to interested GOB officials. An effective model for cost recovery under the DUICSP has not been developed. The model for urban service delivery under the DUICSP and under the ADPs will be different, however.
	What are the costs? • Unit cost per intervention • What is the budget breakdown: @Recurrent costs • Capital costs	These are described in detail in Section 6.a of this report.
WV Staff	Whatwillbethestafling pattern. logistical support, and time frame for integration with the ADP?	The staffing pattern is shown in the organizational charts for each ADP in Section 4.b. 1. The time frame for development of the strategy for each ADP, according to interviews with ADP Coordinators, is hvo years. During this time, baseline surveys and PLA exercises with the community will be carried out. Decisions regarding logistical support for staff will be a part of the development process.
	What are donor expectations for continuation of services?	USAID would like to maximize the sustainability of the impact of the interventions carried out under the DUICSP.

	What is Senior Management's expectation of the level of CS activities included under the ADPs?	Senior management expect that clinic services will be continued under the ADPs and that the existing community structure will be used in some way. They expect, however, a shift of emphasis away from the CCCs, NHCs, and CVs and toward FMGs and TBAS.
	Identify specific actions to link evaluation findings with the QIP and with other WVCS projects.	Opportunities have been identified for sharing lessons leamed, training staff, and sharing materials. (See Section 6.b.)
	After phase out, what will be the changed roles of CVs, CCC members, NHC membetx. FMGs, and TBAS?	These roles have yet to be established. (See Final Evaluation recommendations.)
	Recommendations of team members or USAID for special add-on funding.	Team members have suggested that the project consider HASAB funding available through the European Union for STD/AIDS, and funding by the ADB; subgrants/subcontracts for capacity building of community-based organizations and/or NGOs; and an integrated services model with a focus on child health and reproductive health, a package attractive to many donors.
	What is the minimum package of activities which canbesustainedandits cost?	The cost of the minimum package of clinic services under the DUICSP is estimated to be $37,785 in Mohammedpur and $41,812 in Kamalapur. (See Section 4.b. 1.)
	Compare the sustainability plan with status/ achievement in terms of sustainabiii ty .	Sustainability targets have been largely achieved, with the exception of cost recovery. These have been compared in Section 4.f of this report.
	Reevaluate the health services package to be offered and priorities after phaseover.	Such a reevaluation of the package is a key recommendation of this evaluation. (See Section 1 .e.)
Other Stakeholders	Identify specific actions to link evaluation findings with the QIP and to other WVCS oroiects.	Opportunities have been identified for sharing lessons learned, training staff, and sharing materials. (See Section 6.b.)

Community Members	Has the project been helpful to the community or not and how helpful?	Community members interviewed felt that the project had been very helpful to them. A PLA exercise was conducted to identify the areas in which the community saw change. Most participants in the exercise knew the project well and saw it as successful. (See Section 4.d and Appendix IV.)
	How will services continue after phaseover?	Clinic services will continue as before. Links with established community organizations have yet to be determined.
	After phaseover, what will be the changed role of CVs, CCC members, NHC members, FMGs, and TBAs?	These roles under the new ADPs have yet to be determined.

a. Results of Costing Study and Financial Management

Following is an Expenditure Statement by intervention along with a pie chart graphically displaying this breakdown. EPI, safe motherhood, and ALRI each accounted for approximately 20 percent of project expenditures during the three-year period of phase three of the project. ORT, a mature intervention, accounted for 10 percent, as did family planning. Nutrition accounted for 17 percent of the total expenditures.

By far, the largest expense category was salary and benefits accounting for 63 percent of all expenditures, followed by supplies (9%) and rent and utilities (8%).

The actual recurrent cost per beneficiary was computed by the project Financial Officer by intervention for phase three, as follows:

EPI: The cost to fully immunize a child by age 12 months was $3.23. The cost of TT2 per woman 15-45 years was $3.02.

ORT: The cost per beneficiary is $ .30.

Nutrition: The cost per beneficiary was $1.08.

Family Planning: The cost per eligible couple in union practicing a modem method of contraception was $3.18.

Community
Participation: The cost per beneficiary was $ .34.

(See Appendix X for the definition of Recurrent Costs.)

The total expenditures at the time of the Final Evaluation were $745,891 compared to a budget of $777,826. This close correspondence suggests that the initial budget was well-prepared and that financial management has been good.

COMPONENT-WISE EXPENDITURE STATEMENT

from October '94 - Aug '97

Dhaka Urban Integrated Child Survival Project

Figures in US$

Account Ti tie	EPI	ORT	SM	ARI	FP	NUTRITION	TOTAL
Salary & Benefits	118,259	47,304	94,607	94,607	47,304	70,955	473,036
	(25%)	(70%)	(20%)	(20%)	(10%)	(15%)	(63.42%)
Training/Workshop	3,367	3,367	6,735	8,419	5,051	6,735	33,674
	(10%)	(10%)	(20%)	(25%)	(15%)	(20%)	(4.51%)
Travel/Trans-Vehr	6,138	3,069	4,604	6,138	3,069	7,673	30,691
	(20%)	(10%)	(15%)	(20%)	(10%)	(25%)	(4.11%)
Supplies	6,513	6,513	13,026	16,283	6,513	16,283	65,131
	(10%)	(70%)	(20%)	(25%)	(10%)	(25%)	(8.73%)
Rent & Utilities	14,436	5,774	11,549	11,549	5,774	8,662	57,744
	(25%)	(70%)	(20%)	(20%)	(10%)	(15%)	(7.74%)
Repair & M. Non-Veh.	1,402	491	1,753	1,753	701	911	7,011
	(20%)	(7%)	(25%)	(25%)	(70%)	(13%)	(0.94%)
Communications	3,045	3,045	9,134	7,612	1,522	6,089	30,447
	(10%)	(10%)	(30%)	(25%)	(5%)	(20%)	(4.09%)
Professional services	8,210	2,052	8,210	10,262	4,105	8,210	-41,049
	(20%)	(5%)	(20%)	(25%)	(10%)	(20%)	(5.51%)
Capitlal Expenditure	3,555	355	1,777	355	355	711	7,108
	(50%)	(5%)	(25%)	(5%)	(5%)	(10%)	(0.95%)
Total	164,925	71,970	151,395	156,978	74,394	126,229	745,891
	(22.11%)	(9.65%)	(20.30%)	(21.04%)	(9.97%)	(16.93%)	(100%)

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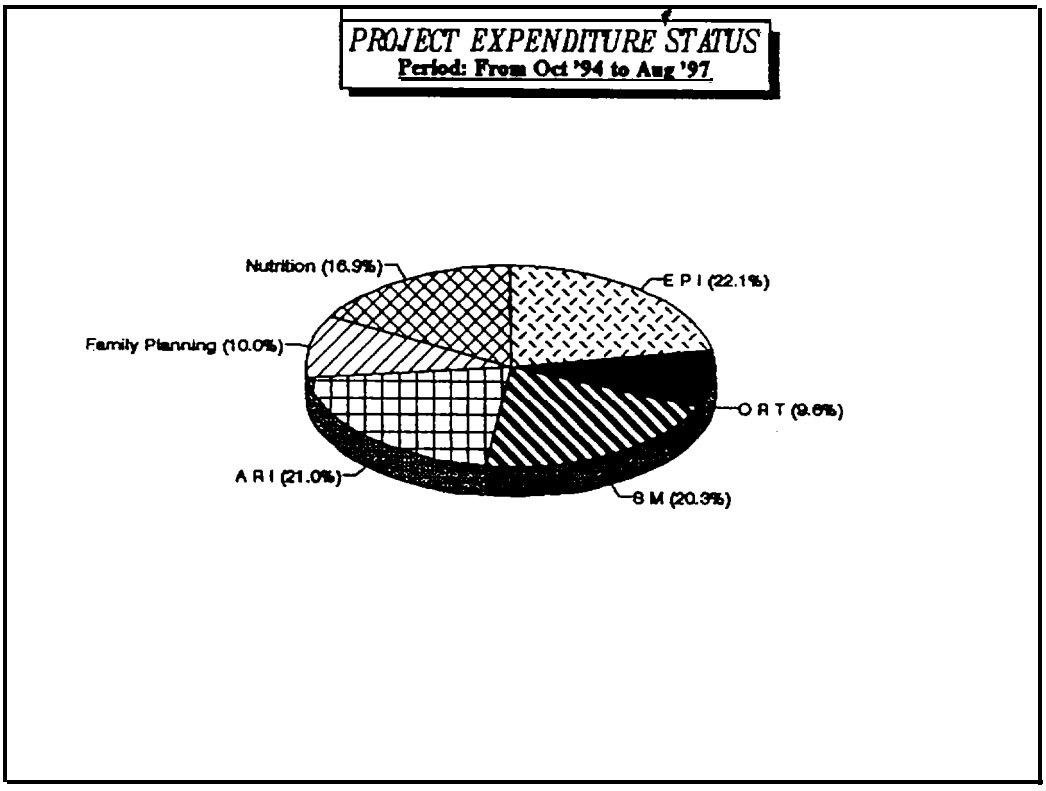
Interventions	Total in US$
E P I	164,925
O R T	71,970
S M	151,395
A R :	156,978
Family Planning	74,394
Nutrition	126,229
T o t a l	**745,891**



b. Linkages with the USAID-Funded QIP

The evaluation team was fortunate to have among its members Dr. Abu Jamil Faisal, Country Director of AVSC, one of the partners in the QIP. He identified several areas in which activities under the QIP could be linked with health activities to be continued under ADPs after the phaseover of the DUICSP. These were presented during a half-day workshop to discuss findings and recommendations. The areas of linkage discussed include the following:

- QIP can support WVB in sharing lessons learned, especially regarding:

  - Continuous Quality Improvement (CQI) activities conducted under the DUICSP, including an operations research study on maternal referrals;
  - Developing an effective and functioning community network as a model for urban service delivery in Bangladesh;
  - One-stop service delivery and the incorporation of new services; and,
  - Management of child health services.

  Some WVB staff who had earlier worked in the DUICSP are now involved in the QIP. This will help the QIP to learn from the experiences of the DUICSP.

- Exit interview have been conducted to assess the quality of activities under the DUICSP, QIP is developing new ways of collecting customers' perceptions on a regular basis and feeding the results back into projects to improve services. These methods can be incorporate into the health activities of the ADPs;

- A CQI Training Manual was recommended in the Mid-Term Evaluation to be developed for local NGOs to put into use. As this has not been done, the QIP has taken the experience of WVB on doing PLA exercises and using CQI tools to institutionalize a methodology of problem identification and resolution by service providers. In this QIP methodology, the supervisory system will become facilitative in nature. QIP is developing a handbook for supervisors, program managers, and policy makers. WVB can collaborate with the QIP in developing this handbook, as well as in other QIP initiatives, rather than developing a separate CQI Training Manual; and,

- Although the DUICSP has been following guidelines available in various national and international service delivery documents, there are no written standards for maternal health and family planning service delivery in the clinics. Technical standards and service delivery guidelines are now being compiled by the QIP. These can be used for health services under the ADPs.

7. Innovations and Lessons

a. Innovations, New Methods, Strategies, and Materials

The DUICSP developed a number of innovative methods, strategies, and materials throughout the life of the project of development relevance both within and outside of Bangladesh. Some of the most important are discussed here.

The project conducted a Missed Opportunity Survey in August 1994 to attempt to provide solutions to problems of low immunization coverage. The study, conducted in both WVB clinics and nearby government referral sites, found that an average of 12 percent of children under two missed immunization opportunities. This percentage varied from 0 to 33 percent, according to the health facility, with greater missed opportunities in government referral sites. In order to increase immunization coverage at every opportunity (e.g. home visits, immunization sessions, during Vitamin A distribution, antenatal/postnatal visits by trained TBAs, ORT demonstration sessions), the project promoted the checking of children's immunization cards, offering any immunizations due, and the updating of records appropriately. Checklists were also introduced to assess EPI performance of health workers.

During the third phase of the child survival project, with the encouragement of the AR1 Directorate, the project organized an ALRI working group with members from the MOHFW, ARI Directorate; UNICEF; WHO; ICDDR,B; the Asia Foundation; Pathfinder; the Aga Khan Foundation; and Johns Hopkins University, Population Communications Program in order to develop IEC materials on pneumonia. The working group developed messages and materials to promote change in mothers' behavior regarding pneumonia. Materials were pretested, and a flipbook and a poster for Education on Pneumonia Prevention and Treatment was prepared. The MOHFW AR1 Directorate printed 30,000 copies of the flipbook and 25,000 copies of the poster and introduced it throughout Bangladesh. A video was also produced in Bangla for community mothers in the DUICSP on ALRI.

The project has been a leader in the use of qualitative methods to improve the quality of interventions. To monitor what mothers have learned about the dietary management of diarrhea, for example, qualitative data were collected through focus group discussions and key informant interviews. These qualitative techniques revealed, for example, that continuous feeding during diarrhea was not being practiced properly because mothers, especially those of low income, perceived it as a waste of food. Both project staff and community members were recently trained in PLA techniques. During the course of this evaluation, two PLA exercises were conducted by community members to assess changes perceived in the project and community ownership of the changes. One of the community members had been previous trained in PLA techniques by project staff. These lessons learned on qualitative methods are being incorporated into materials being developed on the QIP project for national use by government and NGOs.

The DUICSP in October 1994 introduced a CBDS system in the project area. The CBDS system is used to monitor vaccine-preventable diseases, especially polio, tetanus, and measles, and to track EPI coverage. Information is also collected on deaths of children under five and women of child-bearing age by cause. Information is currently being reported by volunteers at all levels and by community people (through volunteers). Technical assistance was received from ICDDR,B and the EPI Directorate in conducting verbal autopsies.

The project introduced CQI techniques into the project beginning with a training workshop in March 1995. The workshop emphasiid developing team approaches to improving quality through operations research. Following the workshop, DUICSP staff prepared a operations research proposal for a study of "Failure of Referrals in Relation to High-Risk Pregnancies and Obstetric Emergencies. " The studies was conducted, and the Country Director of AVSC, a QIP partner, has suggested sharing lessons learned in the study through the QIP mechanism.

TBAs have been trained and have been cooperating with the DUICSP in reporting information. "Gold Standards" developed by Johns Hopkins University were used to design and assess TBA refresher training.

b. Lessons Learned

Lessons learned regarding the project which are applicable to other PVO CS projects or relevant to USAID's support of these projects were identified by project staff. These were as follows:

Quality

- On-site supervision is very important, because, "often people will do what you inspect, not necessarily what you expect;"
- Exit interviews, focus group discussions, and missed opportunity surveys are useful in assessing client satisfaction and improving the quality of services;
- Beneficiaries are willing to pay for quality services if affordable;
- Effective orientation and training for all level of workers and supervisors is important for ensuring quality in program implementation and supervision;
- Need-based development and social analysis training for field workers is very effective and strengthens their confidence.

Management

- Team approaches are very effective in improving the quality of training, services, and management. Participatory management and self assessment in a team help in identifying problems and improving performance.

- One-stop service delivery, supported by limited community-based services, can minimize unmet need.

- Qualified staff are needed in several technical areas (e.g. family planning, treatment, maternal services, and EPI) to render "one-stop" services.

HMIS

- Local terms need to be used in KPC survey questionnaires.

- Extensive data gathering and paperwork can take away much needed time from service delivery.

- After introducing community-based death surveillance, the project obtained useful information on neonatal and under-one deaths, especially regarding neonatal deaths from asphyxia caused by prematurity and prolonged labor.

- CBDS is ineffective if no action is taken after obtaining information from the community.

- Some IEC material related to CBDS is helpful in making the community aware of the need for this information.

Community

- The role of FMGs need to be highlighted as they act as a catalyst in slum areas.

- Female CVs have a lower dropout rate (< 10%) compared to male CVs (40%).

- Income generation activities can be very helpful in making health components more attractive and relevant if linked to CV, NHC or TBA groups.

- A high level of community participation in child survival projects can lead to increased harmony and closer relationships among community members from different religious groups and social classes.

ORT and Diarrhea Disease Control

- Knowledge of ORT is not sufficient in order to change practices with regard to the treatment of the effects of diarrhea. Some wealthier mothers give their children antibiotics or other drugs before using ORT during diarrhea because of the perception that ORS is only for poorer people.

- It is important to promote the use of safe drinking water in all household tasks, including in the preparation of ORS, in order to decrease diarrheal episodes. The problems of inadequate clean water supplies and poor sanitation must be addressed along with ORT education.

Vitamin A and Nutrition

- As mothers become increasingly aware of the importance of Vitamin A, they will take initiative in going to distribution sites during NIDs to obtain Vitamin A capsules. This makes home distribution less necessary thereby reducing program costs.

- Income generation was found to be very important in ensuring food security and adequate nutrition for children, especially for girl children who often eat last in the family.

- Education does not necessarily lead to improved hygiene in preparing foods when the traditional food cooking and storage systems are in question.

EPI

- It is easier to attain high levels of 'IT2 coverage among pregnant women. Women who are not pregnant or planning to become so are less responsive to educational campaigns. To increase coverage of non-pregnant women, therefore, special campaigns for increasing TT coverage can be effectively conducted in girls' schools and colleges as well as in garments factories.

- Special campaigns like NID, Vitamin A Week, and MCH Fortnight must involve the community and reinforce their participation to be successful.

- Ignoring qualified doctors and general practitioners during motivational campaigns can jeopardize immunization services. Those of higher income do not respond to mass mobilization efforts but need to be consulted nonetheless.

- To increase immunization coverage, it is important to concentrate on the slum population with extensive social mobilization and active community participation.

ARI

- The confidence of mothers in seeking treatment for their children with pneumonia depends upon the availability of quality services at the time of need;

Family Planning

- Clients show less interest in counselling for family planning methods and associated problems when they are not provided with the methods at the same site.

- There has been too little effort given to male partners to motivate/counsel women in accepting family planning methods. This may be due to a lack of male counsellors.

- Couples will not accept advice from CVs who are primarily young people and usually unmarried. This problem can be overcome by using FMGs, who are older and married, instead of CVs to raise awareness among women about family planning.

MCH Services

- Affordable maternal care services at the doorstep of beneficiaries enhance acceptance of antenatal checkups.

- Technical support for TBAs as well as attention to the role of male partners as decisionmakers within the family is important in strengthening referral linkages with hospitals/clinics for emergency obstetric care.

The DUICSP has conducted lessons learned workshops, participated in GO/NGO Forums, and shared lessons learned at international conferences. For example, the Project Director and National Health Advisor presented a paper on the DUICSP at the Harvard School of Public Health. In October 1994, the DUICSP staff presented a paper on community ownership of mothers and children's health needs at a conference entitled "Community Impact of PVO Child Survival Efforts, 1985-1994" in Bangalore, India.

8. Achievements and Constraints

a. Conclusions Regarding Achievement of Objectives

The DUICSP has done an outstanding job in meeting its impact and sustainability objectives (see Section 4).

b. Most Important Achievements

The most important achievements of the project, as identified by project staff as well as members of the Evaluation Team, are the following:

- Organizing and empowering the community;
- Decreasing morbidity in the community, including dehydration due to diarrhea, night blindness, malnutrition, pregnancy complications, and vaccine-preventable diseases; and,
- Developing new and innovative methods and strategies which can be used as a model for urban service delivery

The factors contributing to these achievements have been discussed.

c. Problems Overcome and Constraints

Not surprisingly, a number of problems were encountered in implementing the project. Following are a few of them along with a discussion of actions taken by project staff to overcome them:

- Initially the dropout rate for CVs was very high (about 30%). Many CVs were young, single college students. They often dropped out after marriage, when finding employment, or when beginning higher studies. Some also moved outside the area. To address this problem, responsibility for selection was given to the community through the NHCs. The dropout rate of CVs selected by the community has fallen to 11 percent.
- In focus group discussions, project staff identified harmful nutritional practices in the community, especially with regard to eating during pregnancy and feeding children after diarrhea. For example, pregnant women believed that eating burnt mud during pregnancy was good for the health, and that feeding vegetables to children could cause diarrhea. Harmful practices were addressed by educating CVs, TBAs, and members of FMGs, all of whom were members of the community. CVs later reinforced correct messages in home visits. Seeds were initially given to a few families to encourage the growing of Vitamin A-rich vegetables.

- Many families in the project area lack access to sanitary latrines and safe water. This lack of access has increased the incidence of diarrhea. Early in the project, the DUICSP promoted the construction of tubewells and latrines. This resulted in an increase in the rent for houses where latrines had been installed, in some cases, and disputes over who owned tubewells. Staff then turned over involvement in sanitation and water to the NHCs and CCCs.

- Problems were encountered in educating illiterate slum mothers to recognize the importance of prompt treatment for ALRI, especially in very young children. Local terms were used to facilitate the understanding of mothers. Also, a filpchart, a poster, and a video were developed for use in educating mothers.

- Low literacy rates among women with children under two necessitated the development of IEC materials which were largely pictorial as well as pictorial reporting forms for FMGs and TBAs.

Other problems and ways in which project staff have tried to overcome them have been dealt with in other sections of this report. Briefly, these problems have included income generation, missed opportunities for vaccination, relunctance to accept family planning advice from unmarried youth, home visits by CVs, and delays in referral for obstetric emergencies.

Other more general constraints have been identified which impeded the achievement of project objectives including:

- High rates of migration impeded the project in a number of ways. Those who migrated most frequently tended to be of high-risk. Project staff and volunteers experienced difficulties in following up on defaulters and others at risk. Project impact was lower in areas with higher migration (see Section 5.a).

- The relatively high proportion of mothers who had some work outside the home (13%) hindered the promotion of breastfeeding;

- There was gender bias against girls resulting in higher rates of malnutrition for girls. (Girls ate after other family members.)

- Early marriage, with women averaging less than 18 years of age at first marriage, contributed to pregnancy-related mortality;

- There was widespread poverty, poor environmental conditions, frequent natural disasters (e.g. flooding), and political instability in the area.

Appendix III. Summary and Recommendations of Mid-Term Evaluation

Executive Summary

- The Dhaka Urban Integrated Child Survival Project (DUICSP) provides Maternal and Child Health Services to 210,000 people in Dhaka, Bangladesh. An estimated one-third of the population are urban poor living on $1-2 per day.
- The DUICSP, initiated in 1987, is in its third and final stage of USAID central funding and will terminate September 30, 1997.
- From August 17-27. 1996, a national-international team, facilitated by Professor Stanley Foster of Emory University's Rollins School of Public Health, carried out a mid-term evaluation aimed at identifying "steps that should be taken by the PVO field staff and headquarters for the project to achieve its output and outcome objectives." The evaluation included a 2day Government-NGO workshop, "Using Data to Improve Urban Health."
- From the perspective of Primary Health Care, as envisioned at Alma Ata in 1978, DUICSP has achieved a remarkable partnership with the community (Neighborhood Health Committees, Focus Mothers, TBAs, and Community Volunteers); project staff; Dhaka Cii Corporation, and the GOB.
- Structure and services are decentralized to the cluster (400 family) level. Certain services are delivered door-to-door (semi-annual distribution of vitamin A; registration, and health promotion), other services are delivered at collecting points (Polio NIDs and Measles Tetanus Campaigns to immunize defaulters); and others are provided at the four project health facilities (immunization, maternal care and treatment of minor illness).
- Quality of preventive and treatment services was excellent.
- Data collected by the 1995 KPC Survey and HMIS show good progress toward the 16 objectives.
- Observed rates of night blindness and reported cases of disease preventable by immunization have fallen.
- The project has achieved a remarkable degree of ownership by the community with significant inputs in cost recovery and volunteer labor.
- Considering the high percentage of urbanpoor within the catchment area, it is unreasonable to expect that the project can be financially self sustaining. Two major urban health projects will come on line in the next 24 months: an ADB loan for urban health and an USAID urban health services project.
- **DUICSP is one of the more, if not the most, successful of urban health projects in Bangladesh.** Its value extends far beyond its direct health effects to its success in empowerment at the community level and to its framework as a viable strategic option for urban health.
- The evaluation team identified a number of areas where program strengthening needs to be considered. These include the addition of family planning service, the integration of service delivery, and the rationalization of a burdensome information system to ensure the availability and use of data at the local level. **These are** detailed in the recommendations **on the next page and** throughout this **report.**
- The evaluation **team is unanimous in strongly recommending a search for bridge funding to ensure** momentum **pending new funds coming on line.**

Recommendations

Recommendation 1: Project staff and client communities explore strategies to ensure the daily and simultaneous availability of treatment of illness, immunization, maternal care, and family planning at all facilities. Such a review will require an assessment of personnel and facilities to maximize use of resources. Provision of space to community for literacy training should be explored.

Recommendation 2: Given the importance of fertility choice as a human right and the high attributable risk of poorly timed pregnancies (too early, too quick, too many, and too late) to neonatal, infant and maternal mortality, the project explore options to increase access to family planning services. Project explore associating with an NGO providing quality family planning services to facilitate the expansion of the current package of services.

Recommendation 3: Project develop a continuing education curriculum for each set of monthly meetings using a 12-month calendar of major issues. Disease specific subjects should be linked to the epidemiological calendar; e.g., identification of measles susceptibles 936 months (Ott-Nov); recognition, referral, and treatment of ARI/Pneumonia (De&an); prevention and treatment of diarrhea (May-June).

Recommendation 4: Project utilize framework provided during the "Using Data to Improve Urban Health Workshop' to review current HMIS and place priority on systems for which meaningful information is being collected and used. Use data to identify hiih risk areas for priority allocation of resources.

Recommendation 5: Project be commended for the progress being made in the collection of mortality data. Project utilize locally available technical assistance to upgrade staff and project understanding of the value and use of verbal autopsy data at the community and program levels.

Recommendation 6: Project review its current demands for data collection of CVs and CDWs and, if appropriate, modify procedures to reflect need, understandability, and use.

Recommendation 7: Project management review the current use of the Nutrition Rehabilitation Unit in terms of impact and use of resources.

Recommendation 8: DUICSP implement the new EPI Guidelines for CBDS.

Recommendation 9: Project be commended on its ARI/Pneumonia collaboration with ICDDR/B. Project management meet with the Urban Health Extension Project to share project experience and to explore how the project can better use the 'goldmine' (Sonar *Khoni*) of information available from urban research.
Recommendation 10: That World Vision 1) recognize the developmental relevance of its current project to the future of urban health in Bangladesh, 2) reconstitute DUICSP as a local NGO so as to have access to funding, 3) explore bridge funding to ensure continuity until new funding is on line, 4) explore opportunities for funding through the DCC and its ADB loan and the new USAID Urban Service Delivery Project, and 5) that it consider splitting the project with incorporation of the Mohammedpur project into the proposed Dhaka Urban ADP and the promotion of the Kamalapur segment for urban service delivery.

Recommendation 11: The final evaluation of the DUICSP be designed to capture project achievements in terms of progress toward objectives, cost, and developmental relevance. Explore video documentation.

Recommendation 12: USAID acknowledge its privilege of partnership with the DUICSP, that it officially convey to the project and its community partners its admiration for its achievements, and it share this effective humanitarian empowerment use of foreign assistance with USAID-Washington.

Appendix IV. Reports of PLA Exercises

During the Final Evaluation, PLA Exercises were conducted with slum mothers in each of the project areas by community representatives participating on the evaluation team. The community representatives took responsibility for developing the exercises, conducting them, and reporting the results. Following are their unedited reports.

Report from Kamalapur:

PLA Exercise with Slum Mothers

Place: 14 Outfall (Rokeya's House)

Knowing About	Yes	No
Project Office	10	2
Project Staff	11	1
About Medicine	10	2
Refer to Hospital	11	1
Vitamin A Capsules	12	0
Delivery Checkup	11	1
Immunization	12	0
Immunization to Pregnant Mother	12	0
Treatment of Diarrhea	12	0

Source of information: Focus mother, community volunteer, field worker, drama.

Changing: Cure of nightblind, diarrhea disease, TB, decreases of death rate of children. Tetanus, HUM, Basanto, Huping, Phenomonia, Diptheria, Polio.

In the above participants are saying that the WVB has done their job in our community well for the welfare of the children and their mothers about the above six diseases and also growing awareness of slum people health education, nutrition, and also created a lot of community volunteer in good moral character for human being. We are greatful to the project and their staff who are the most responsible to do a such kind of good job. Thanks.

Cause of change:

1. There is no nightblind in the community.
2. They are knowing how to prepare ORS.
3. No tetanus infection in delivery cases which occurs regularly in cases.
4. To get useful immunization.

Project staff: They identifying the project staff.

Most responsible person is: Focus mother.

Report from Mohammedpur:

As part of PLA on 24th September 97, we went to a slum area "Sakar Tak" in Dhaka City.

We met 15 women who are between 16 to 50 years. We sat in one of their rooms.

We first asked them did any one hear about child survival project? Ten out of 15 answered that they heard about it. My second question, how did they know? They answered they know about this from the volunteer who regularly visited them. Anothers knew about it from the project office.

They also said about the benefit from the project they received. EPI vaccination for their children. The mothers and the young girls get TT vaccines. Twelve women out of 15 said that they got their vaccination from the project office.

Two were new comers and came one year back. We went there when they were preparing dinner. Ten of them informed that project office provided them with medical and natal care. When they became pregnant, they visited the office. The nurse measured their blood pressure and made their examination. She advised them about their diet and provided calcium tablet. One of them told me that the project should provide safe delivery facility.

Appendix V. World Vision Protocol for Final Evaluation

A. PROJECT BACKGROUND;

Through a grant from the United States for International Development to World Vision Relief and Development Inc. (WVRD), World Vision of Bangladesh's Dhaka Urban Integrated Child Survival Project (DUICSP) is working in 8 wards of Dhaka city to increase child health and survival. The main purpose of the final evaluation is to assess progress towards achieving the goals and objectives outlined in the project Detailed Implementation Plan (DIP) dated march 31, 1995 as compared to the baseline survey carried out on October/November, 1994.

The project period extends from October 1, 1994 to September 30, 1997 and serves an estimated population of 249,000. Conduction of the Final evaluation is a condition of the grant.

B. SIGNIFICANCE OF THE FINAL EVALUATION;

The DUICSP is unique is several respects:

- It focuses on a rapidly growing urban area with a floating population of 12-15 percent.
- It serves a population in areas in which the DCC presence is focused primarily on immunization.
- It addresses a broad rang of preventive (family planning, immunization, antenatal postnatal, breastfeeding, Vitamin A) and curative (diarrhoea and pneumonia) services.
- The project has a well-functioning HMIS providing a broad range of information on utilization, coverage and impact.
- Community participation and ownership (involving all population subgroups viz NHCs, CVs, TBAs, FMGs, Local NGOs, etc) has been maximal and crucial to the project's accomplishments.
- The project transcends the targeted interventions (3-4) characteristic of the child survival projects of the last decade and may possibly be a model for the next generation of child survival projects in urban Bangladesh.
- The project provides quality services from three static centres to be the model of "one stop-shopping" as recommended by the MTE team.

C. OBJECTIVES OF THE FINAL EVALUATION;

- ¤ Assess project achievements in meeting stated objectives and yearly targets and project effectiveness in reaching targeted high groups, in terms of quantifiable outputs and outcomes and qualitative measures of performance by each intervention.

- ¤ Identify major factors contributing to the project's achievements and document lessons learned

- ¤ Review steps undertaken by the project to promote sustainability of child survival activities once project funds end, and assess the integration process with ADPs for sustainability of child survival interventions.

- n Make key recommendations for improving project service, quality and impact and future directions of the project in terms of effective integration with the follow-on ADP.

- ¤ Address priority questions identified by each of the clients of the Final Evaluation.

- ¤ Review the project's community organization strategies and mechanisms and make recommendations to interlink with ADP.

- ¤ Recommend steps to link the Quality Improvement (QI) activities of the follow-on ADP with the new USAID/Dhaka's Quality Improvement Program (QIP).

- ¤ Recommend strategies for a low-cost model to one stop integrated delivery of quality child survival and reproductive health services.

- ¤ To conduct cost-efficiency and cost-effective analyses of the project where possible.

- ¤ Communicate key evaluation findings, conclusions and recommendations to clients of the Final Evaluation and document them in the form of Final Evaluation (FE) Report which should include the following:

  - Composition of the FE Team
  - Time spent
  - Total costs
  - Field Visits
  - Qualitative and quantitative methods used
  - Main project accomplishments and measurable outcomes

- Assessment of applicability and quality of child survival programming
- Relevance of lessons learned to other child survival and community development programs
- Key recommendations
- Planned or actual feedback of evaluation results
- Author(s) of the Final Evaluation Report

D. PROPOSED DATES:

October 18-30

E. EVALUATION METHODOLOGIES TO BE USED;

- Analysis and interpretation of the results of the standard 30 cluster Knowledge, Practice, Coverage (KPC) survey of 420 mothers with children under two years.
- An internal evaluation based on data generated by the HMIS
- A clientcentred evaluation where each of the clients is asked to identify 3-5 priority questions to be addressed by the evaluation.
- Field Visits/observations
- Focus group discussion and key informant interviews with stakeholders
- Participatory Learning and Action (PLA) exercises with project communities
- Review of available project documents
- Others as required by the Final Evaluation Team

F. COMPOSITION OF THE FINAL EVALUATION TEAM;

Lead Evaluator:

Ms. La Rue K. Seims, MPH, MA
Consultant, Public Health
Ex-WHO Advisor, School Health Project
Dhaka, Bangladesh

Coordinators:

- Dr. Ratu Gopal Saha
  National Health Coordinator
  World Vision of Bangladesh